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Supreme Court, U.S.
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No. 05-200

IN THE

Supreme Court of the United States

EMPIRE HEALTHCHOICE ASSURANCE, INC.
Doing business as Empire Blue Cross Blue Shield,
Petitioner,

v.

DENISE FINN MCVEIGH, as administratrix
of the Estate of Joseph E. McVeigh,
Respondent.

**On Writ of Certiorari to the
United States Court of Appeals for the Second Circuit**

JOINT APPENDIX
VOLUME 1

HARRY RAPTAKIS
Counsel of Record
for Respondent
88 Second Street
Mineola, N.Y. 11501
Tel: (516) 739-5140

ANTHONY F. SHELLEY
Counsel of Record
for Petitioner
MILLER & CHEVALIER
CHARTERED
655 15th Street, N.W., Ste. 900
Washington, D.C. 20005
Tel: (202) 626-5800

Petition for Certiorari Filed August 8, 2005
Certiorari Granted January 6, 2006

Table of Contents - Volume I

Chronological List of Relevant Docket Entries from the United States District Court for the Southern District of New York 1

Chronological List of Relevant Docket Entries from the United States Court of Appeals for the Second Circuit 4

Excerpts from H.R. Rep. No. 105-374 (1997) 6

Letter from Victor A. Carr to David M. Berger, dated December 17, 1999 27

Hearing Transcript in *Finn v. Town of Southampton* in the Supreme Court of the State of New York, County of Suffolk, dated March 19, 2003 29

Complaint filed in the United States District Court for the Southern District of New York, dated April 18, 2003 40

Declaration of Clinton Shatzer filed in the United States District Court for the Southern District of New York, dated June 19, 2003 49

Empire HealthChoice Assurance, Inc.'s Response to Defendant's Statement of Material Facts, dated July 3, 2003 52

Plaintiff's Opposition to Defendant's Motion to Dismiss and for Summary Judgment, dated July 3, 2003 54

Table of Contents - Volume I, Continued

The following opinions, judgments and orders, and other parts of the record have been omitted in printing in this joint appendix because they appear on the following pages of the appendix to the Petition for Certiorari:

Opinion & Order for the United States District Court for the Southern District of New York, dated September 18, 2003 ..... 54a

Judgment for the United States District Court for the Southern District of New York, dated September 23, 2003 ..... 63a

Memorandum Opinion of United States Court of Appeals for the Second Circuit, dated January 14, 2005 ..... 1a

Brief for the United States as *Amicus Curiae* Supporting Appellant's Petition for Rehearing and Rehearing *En Banc*, dated February 2005 ..... 65a

Memorandum Opinion on Petition for Rehearing By the Panel for the United States Court of Appeals for the Second Circuit, dated March 16, 2005 ..... 46a

Order By the Panel for the United States Court of Appeals for the Second Circuit, dated May 10, 2005 ..... 52a

U.S. District Court
Southern District of New York (Foley Square)
Relevant Docket Entries for *Empire HealthChoice Assurance, Inc. v. McVeigh*, No. 1:03-cv-02728-DLC

Date Filed	#	Docket Text
04/18/2003	1	COMPLAINT filed. Summons issued and Notice pursuant to 28 U.S.C. 636(c)
04/18/2003	2	RULE 7.1 CERTIFICATE filed by Empire HealthChoice
04/18/2003	3	EXHIBITS A to B by Empire HealthChoice
04/18/2003	4	EXHIBITS C to J by Empire HealthChoice
04/24/2003	5	AFFIDAVIT OF SERVICE of summons and complaint as to Denise Finn McVeigh by personal service on 4/21/03 . Answer due on 5/12/03 for Denise Finn McVeigh
06/05/2003	7	ANSWER to Complaint by Denise Finn McVeigh
06/06/2003	6	NOTICE OF MOTION by Denise Finn McVeigh to dismiss for lack of jurisdiction purs to FRCP Rule 12(a); purs to FRCP Rule 12(6) dismissing action for failure to state a claim upon which relief can be granted; for summary judgment dismissing plaintiff's complaint; dismissing action because it was not commenced within the applicable Statute of Limitations to assert the claims presented

Date Filed	#	Docket Text
07/03/2003	9	RESPONSE by Empire HealthChoice to defendant's statement of material facts
07/03/2003	10	MEMORANDUM OF LAW by Empire HealthChoice in opposition to motion to dismiss for lack of jurisdiction pursl to FRCP Rule 12(a), motion purs to FRCP Rule 12(6) dismissing action for failure to state a claim upon which relief can be granted, motion for summary judgment dismissing plaintiff's complaint, motion dismissing action because it was not commenced within the applicable Statute of Limitations to assert the claims presented
07/03/2003	11	DECLARATION of Kieran X. Bastible by Empire HealthChoice in opposition to motion to dismiss for lack of jurisdiction purs. to FRCP Rule 12(a), motion purs to FRCP Rule 12(6) dismissing action for failure to state a claim upon which relief can be granted, motion for summary judgment dismissing plaintiff's complaint, motion dismissing action because it was not commenced within the applicable Statute of Limitations to assert the claims presented
07/11/2003	12	REPLY AFFIRMATION of Victor A. Carr by Denise Finn McVeigh Re: opposition memorandum

Date Filed	#	Docket Text
09/18/2003	13	OPINION & ORDER that this breach of contract and declaratory judgment action between private parties does not raise a federal question. The motion to dismiss for lack of subject matter jurisdiction is granted. The Clerk of the Court shall close the case.
09/23/2003	14	JUDGMENT; it is ordered, adjudged and decreed that for the reasons stated in the Court's Opinion and Order, dated 9/18/03, deft's motion to dismiss for lack of subject matter jurisdiction is hereby granted and the case is closed
09/23/2003		Case closed
10/21/2003	15	NOTICE OF APPEAL by Empire HealthChoice
10/21/2003		Notice of appeal and certified copy of docket to USCA
10/28/2003	16	Notice that the record on appeal has been certified and transmitted to the U.S. Court of Appeals

U.S. Court of Appeals for the Second Circuit
Relevant Docket Entries for No. 03-9098

Date Filed	Docket Text
10/22/03	Copy of notice of appeal and district court docket entries on behalf of Appellant Empire HealthChoice filed
12/10/03	Appellant Empire HealthChoice brief FILED with proof of service
12/10/03	Appellant Empire HealthChoice joint appendix filed w/pfs. Number of volumes: 2
12/30/03	Appellee Denise Finn McVeigh brief filed with proof of service
1/20/04	APPELLANT Empire HealthChoice, reply brief filed with proof of service
1/14/05	Judgment of the district court is AFFIRMED by published signed opinion filed
1/14/05	Judge Sack concurs in a separate opinion, filed
1/14/05	Judge Raggi dissents in a separate opinion, filed
1/14/05	Judgment filed
1/28/05	Appellant Empire HealthChoice motion Petition for rehearing filed with proof of service. petition for rehearing en banc filed with proof of service
2/18/05	AMICUS CURIAE U.S. Department of Justice, brief filed with proof of service
3/16/05	Petition Opinion DENYING appellants petition for rehearing FILED
5/10/05	Order FILED DENYING motion petition for rehearing en banc by Appellant Empire HealthChoice, endorsed on motion dated 2/7/2005

Date Filed	Docket Text
5/16/05	Appellant Empire HealthChoice motion stay the mandate filed with proof of service
5/24/05	Order FILED GRANTING motion stay the mandate by Appellant Empire HealthChoice, endorsed on motion dated 5/16/2005
5/25/05	Appellee Denise McVeigh, opposition statement to motion stay the mandate filed with proof of service
8/17/05	Notice of filing petition for APPELLANT Empire HealthChoice, dated 8/10/05 filed. Supreme Court #: 05-200
1/24/06	The Supreme Court has GRANTED the petition for writ of certiorari

105th Congress Report
1st Session House of Representatives 105-374

FEDERAL EMPLOYEES HEALTH CARE PROTECTION ACT OF 1997

November 4, 1997. -- Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. BURTON of Indiana, from the Committee on Government Reform and Oversight, submitted the following

REPORT

[To accompany H.R. 1836]

[Including cost estimate of the Congressional Budget Office]

The Committee on Government Reform and Oversight, to whom was referred the bill (H.R. 1836) to amend chapter 89 of title 5, United States Code, to improve administration of sanctions against unfit health care providers under the Federal Employees Health Benefits Program, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

* * * * * *

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Federal Employees Health Care Protection Act of 1997".

SEC. 2. DEBARMENT AND OTHER SANCTIONS.

(a) Amendments. -- Section 8902a of title 5, United States Code, is amended --

(1) in subsection (a) --

(A) in paragraph (1) --

(i) by striking "and" at the end of subparagraph (B);

(ii) by striking the period at the end of subparagraph (C) and inserting "; and"; and

(iii) by adding at the end the following:

"(D) the term 'should know' means that a person, with respect to information, acts in deliberate ignorance of, or in reckless disregard of, the truth or falsity of the information, and no proof of specific intent to defraud is required;"; and

(B) in paragraph (2)(A), by striking "subsection (b) or (c)" and inserting "subsection (b), (c), or (d)";

(2) in subsection (b) --

(A) by striking "The Office of Personnel Management may bar" and inserting "The Office of Personnel Management shall bar"; and

(B) by amending paragraph (5) to read as follows:

"(5) Any provider that is currently debarred, suspended, or otherwise excluded from any procurement or nonprocurement activity (within the meaning of section 2455 of the Federal Acquisition Streamlining Act of 1994).";

(3) by redesignating subsections (c) through (d) as subsections (d) through (j), respectively, and by inserting after subsection (b) the following:

"(c) The Office may bar the following providers of health care services from participating in the program under this chapter:

"(1) Any provider --

"(A) whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the providers professional competence, professional performance, or financial integrity; or

"(B) that surrendered such a license while a formal disciplinary proceeding was pending before such an authority, if the proceeding concerned the providers professional competence, professional performance, or financial integrity.

"(2) Any provider that is an entity directly or indirectly owned, or with a control interest of 5 percent or more held, by an individual who has been convicted of any offense described in subsection (b), against whom a civil monetary penalty has been assessed under subsection (d), or who has been debarred from participation under this chapter.

"(3) Any individual who directly or indirectly owns or has a control interest in a sanctioned entity and who knows or should know of the action constituting the basis for the entity's conviction of any offense described in subsection (b), assessment with a civil monetary penalty under subsection (d), or debarment from participation under this chapter.

"(4) Any provider that the Office determines, in connection with claims presented under this chapter, has charged for health care services or supplies in an amount substantially in excess of such provider's customary charge for such services or supplies (unless the Office finds there is good cause for such

charge), or charged for health care services or supplies which are substantially in excess of the needs of the covered individual or which are of a quality that fails to meet professionally recognized standards for such services or supplies.

"(5) Any provider that the Office determines has committed acts described in subsection (d).

Any determination under paragraph (4) relating to whether a charge for health care services or supplies is substantially in excess of the needs of the covered individual shall be made by trained reviewers based on written medical protocols developed by physicians. In the event such a determination cannot be made based on such protocols, a physician in an appropriate specialty shall be consulted.";

"(4) in subsection (d) (as so redesignated by paragraph (3)) by amending paragraph (1) to read as follows:

"(1) in connection with claims presented under this chapter, that a provider has charged for a health care service or supply which the provider knows or should have known involves --

"(A) an item or service not provided as claimed,

"(B) charges in violation of applicable charge limitations under section 8904(b), or

"(C) an item or service furnished during a period in which the provider was debarred from participation under this chapter pursuant to a determination by the Office under this section, other than as permitted under subsection (g)(2)(B);";

(5) in subsection (f) (as so redesignated by paragraph (3)) by inserting after "under this section" the first place it appears the following: "(where such debarment is not mandatory)";

(6) in subsection (g) (as so redesignated by paragraph (3)) --

(A) by striking "(g)(1)" and all that follows through the end of paragraph (1) and inserting the following:

"(g)(1)(A) Except as provided in subparagraph (B), debarment of a provider under subsection (b) or (c) shall be effective at such time and upon such reasonable notice to such provider, and to carriers and covered individuals, as shall be specified in regulations prescribed by the Office. Any such provider that is debarred from participation may request a hearing in accordance with subsection (h)(1).

"(B) Unless the Office determines that the health or safety of individuals receiving health care services warrants an earlier effective date, the Office shall not make a determination adverse to a provider under subsection (c)(5) or (d) until such provider has been given reasonable notice and an opportunity for the determination to be made after a hearing as provided in accordance with subsection (h)(1).";

(B) in paragraph (3) --

(i) by inserting "of debarment" after "notice"; and

(ii) by adding at the end the following: "In the case of a debarment under paragraph (1), (2), (3), or (4) of subsection (b), the minimum period of debarment shall not be less than 3 years, except as provided in paragraph (4)(B)(ii).";

(C) in paragraph (4)(B)(i)(I) by striking "subsection (b) or (c)" and inserting "subsection (b), (c), or (d)"; and

(D) by striking paragraph (6);

(7) in subsection (h) (as so redesignated by paragraph (3)) by striking "(h)(1)" and all that follows through the end of paragraph (2) and inserting the following:

"(h)(1) Any provider of health care services or supplies that is the subject of an adverse determination by the Office under this section shall be entitled to reasonable notice and an opportunity to request a hearing of record, and to judicial review as provided in this subsection after the Office renders a final decision. The Office shall grant a request for a hearing upon a showing that due process rights have not previously been afforded with respect to any finding of fact which is relied upon as a cause for an adverse determination under this section. Such hearing shall be conducted without regard to subchapter II of chapter 5 and chapter 7 of this title by a hearing officer who shall be designated by the Director of the Office and who shall not otherwise have been involved in the adverse determination being appealed. A request for a hearing under this subsection shall be filed within such period and in accordance with such procedures as the Office shall prescribe by regulation.

"(2) Any provider adversely affected by a final decision under paragraph (1) made after a hearing to which such provider was a party may seek review of such decision in the United States District Court for the District of Columbia or for the district in which the plaintiff resides or has his or her principal place of business by filing a notice of appeal in such court within 60 days after the date the decision is issued, and by simultaneously sending copies of such notice by certified mail to the Director of the Office and to the Attorney General. In answer to the appeal, the Director of the Office shall promptly file in such court a certified copy of the transcript of the record, if the Office conducted a hearing, and other evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and evidence of record, a judgment affirming, modifying, or setting aside, in whole or in part, the decision of the Office, with or without remanding the case for a rehearing. The district court shall not set aside or remand the decision of the Office unless there is not substantial evidence on the record, taken as whole, to support

the findings by the Office of a cause for action under this section or unless action taken by the Office constitutes an abuse of discretion."; and

(8) in subsection (i) (as so redesignated by paragraph (3)) --

(A) by striking "subsection (c)" and inserting "subsection (d)"; and

(B) by adding at the end the following: "The amount of a penalty or assessment as finally determined by the Office, or other amount the Office may agree to in compromise, may be deducted from any sum then or later owing by the United States to the party against whom the penalty or assessment has been levied.".

(b) Effective Date. --

(1) IN GENERAL. -- Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act.

(2) EXCEPTIONS. -- (A) Paragraphs (2), (3), and (5) of section 8902a(c) of title 5, United States Code, as amended by subsection (a)(3), shall apply only to the extent that the misconduct which is the basis for debarment under such paragraph (2), (3), or (5), as applicable, occurs after the date of the enactment of this Act.

(B) Paragraph (1)(B) of section 8902a(d) of title 5, United States Code, as amended by subsection (a)(4), shall apply only with respect to charges which violate section 8904(b) of such title for items or services furnished after the date of the enactment of this Act.

(C) Paragraph (3) of section 8902a(g) of title 5, United States Code, as amended by subsection (a)(6)(B), shall apply only with respect to debarments

based on convictions occurring after the date of the enactment of this Act.

SEC. 3. MISCELLANEOUS AMENDMENTS RELATING TO THE HEALTH BENEFITS PROGRAM FOR FEDERAL EMPLOYEES.

(a) DEFINITION OF A CARRIER. -- Paragraph (7) of section 8901 of title 5, United States Code, is amended by striking "organization;" and inserting "organization and an association of organizations or other entities described in this paragraph sponsoring a health benefits plan;".

(b) SERVICE BENEFIT PLAN. -- Paragraph (1) of section 8903 of title 5, United States Code, is amended by striking "plan," and inserting "plan, which may be underwritten by participating affiliates licensed in any number of States,".

(c) PREEMPTION. -- Section 8902(m) of title 5, United States Code, is amended by striking "(m)(1)" and all that follows through the end of paragraph (1) and inserting the following:

"(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.".

SEC. 4. CONTINUED HEALTH INSURANCE COVERAGE FOR CERTAIN INDIVIDUALS.

(a) ENROLLMENT IN CHAPTER 89 PLAN. For purposes of chapter 89 of title 5, United States Code, any period of enrollment --

(1) in a health benefits plan administered by the Federal Deposit Insurance Corporation before the termination of such plan on January 3, 1998, or

(2) subject to subsection (c), in a health benefits plan (not under chapter 89 of such title) with respect to

which the eligibility of any employees or retired employees of the Board of Governors of the Federal Reserve System terminates on January 3, 1998,

shall be deemed to be a period of enrollment in a health benefits plan under chapter 89 of such title.

(b) CONTINUED COVERAGE. -- (1) Subject to subsection (c), any individual who, on January 3, 1998, is enrolled in a health benefits plan described in subsection (a)(1) or (2) may enroll in an approved health benefits plan under chapter 89 of title 5, United States Code, either as an individual or for self and family, if, after taking into account the provisions of subsection (a), such individual --

(A) meets the requirements of such chapter for eligibility to become so enrolled as an employee, annuitant, or former spouse (within the meaning of such chapter); or

(B) would meet those requirements if, to the extent such requirements involve either retirement system under such title 5, such individual satisfies similar requirements or provisions of the Retirement Plan for Employees of the Federal Reserve System.

Any determination under subparagraph (B) shall be made under guidelines which the Office of Personnel Management shall establish in consultation with the Board of Governors of the Federal Reserve System.

(2) Subject to subsection (c), any individual who, on January 3, 1998, is entitled to continued coverage under a health benefits plan described in subsection (a)(1) or (2) shall be deemed to be entitled to continued coverage under section 8905a of title 5, United States Code, but only for the same remaining period as would have been allowable under the health benefits plan in which such individual was enrolled on January 3, 1998, if

(A) such individual had remained enrolled in such plan; and

(B) such plan did not terminate, or the eligibility of such individual with respect to such plan did not terminate, as described in subsection (a).

(3) Subject to subsection (c), any individual (other than an individual under paragraph (2)) who, on January 3, 1998, is covered under a health benefits plan described in subsection (a)(1) or (2) as an unmarried dependent child, but who does not then qualify for coverage under chapter 89 of title 5, United States Code, as a family member (within the meaning of such chapter) shall be deemed to be entitled to continued coverage under section 8905a of such title, to the same extent and in the same manner as if such individual had, on January 3, 1998, ceased to meet the requirements for being considered an unmarried dependent child of an enrollee under such chapter.

(4) Coverage under chapter 89 of title 5, United States Code, pursuant to an enrollment under this section shall become effective on January 4, 1998.

(c) ELIGIBILITY FOR FEHBP LIMITED TO INDIVIDUALS LOSING ELIGIBILITY UNDER FORMER HEALTH PLAN. -- Nothing in subsection (a)(2) or any paragraph of subsection (b) (to the extent such paragraph relates to the plan described in subsection (a)(2)) shall be considered to apply with respect to any individual whose eligibility for coverage under such plan does not involuntarily terminate on January 3, 1998.

(d) TRANSFERS TO THE EMPLOYEES HEALTH BENEFITS FUND. -- The Federal Deposit Insurance Corporation and the Board of Governors of the Federal Reserve System shall transfer to the Employees Health Benefits Fund under section 8909 of title 5, United States Code, amounts determined by the Director of the Office of Personnel Management, after consultation with the Federal Deposit Insurance Corporation and the Board of

Governors of the Federal Reserve System, to be necessary to reimburse the Fund for the cost of providing benefits under this section not otherwise paid for by the individuals covered by this section. The amounts so transferred shall be held in the Fund and used by the Office in addition to amounts available under section 8906(g)(1) of such title.

(c) ADMINISTRATION AND REGULATIONS. -- The Office of Personnel Management --

(1) shall administer the provisions of this section to provide for --

(A) a period of notice and open enrollment for individuals affected by this section; and

(B) no lapse of health coverage for individuals who enroll in a health benefits plan under chapter 89 of title 5, United States Code, in accordance with this section; and

(2) may prescribe regulations to implement this section.

SEC. 5. FULL DISCLOSURE IN HEALTH PLAN CONTRACTS.

The Office of Personnel Management shall encourage carriers offering health benefits plans described by section 8903 or section 8903a of title 5, United States Code, with respect to contractual arrangements made by such carriers with any person for purposes of obtaining discounts from providers for health care services or supplies furnished to individuals enrolled in such plan, to seek assurance that the conditions for such discounts are fully disclosed to the providers who grant them.

SEC. 6. PROVISIONS RELATING TO CERTAIN PLANS THAT HAVE DISCONTINUED THEIR PARTICIPATION IN FEHBP.

(a) AUTHORITY TO READMIT. --

(1) IN GENERAL. -- Chapter 89 of title 5, United States Code, is amended by inserting after section 8903a the following:

" 8903b. Authority to readmit an employee organization plan

"(a) In the event that a plan described by section 8903(3) or 8903a is discontinued under this chapter (other than in the circumstance described in section 8909(d)), that discontinuation shall be disregarded, for purposes of any determination as to that plans eligibility to be considered an approved plan under this chapter, but only for purposes of any contract year later than the third contract year beginning after such plan is so discontinued.

"(b) A contract for a plan approved under this section shall require the carrier --

"(1) to demonstrate experience in service delivery within a managed care system (including provider networks) throughout the United States; and

"(2) if the carrier involved would not otherwise be subject to the requirement set forth in section 8903a(c)(1), to satisfy such requirement.".

(2) CONFORMING AMENDMENT. -- The analysis for chapter 89 of title 5, United States Code, is amended by inserting after the item relating to section 8903a the following:

"8903b. Authority to readmit an employee organization plan.".

(3) APPLICABILITY. --

(A) IN GENERAL. -- The amendments made by this subsection shall apply as of the date of enactment of this Act, including with respect to any plan which has been discontinued as of such date.

(B) TRANSITION RULE. -- For purposes of applying section 8903b(a) of title 5, United States Code (as

amended by this subsection) with respect to any plan seeking to be readmitted for purposes of any contract year beginning before January 1, 2000, such section shall be applied by substituting "second contract year" for "third contract year".

(b) TREATMENT OF THE CONTINGENCY RESERVE OF A DISCONTINUED PLAN. --

(1) IN GENERAL. -- Subsection (e) of section 8909 of title 5, United States Code, is amended by striking "(e)" and inserting "(e)(1)" and by adding at the end the following:

"(2) Any crediting required under paragraph (1) pursuant to the discontinuation of any plan under this chapter shall be completed by the end of the second contract year beginning after such plan is so discontinued.

"(3) The Office shall prescribe regulations in accordance with which this subsection shall be applied in the case of any plan which is discontinued before being credited with the full amount to which it would otherwise be entitled based on the discontinuation of any other plan.".

(2) TRANSITION RULE. -- In the case of any amounts remaining as of the date of enactment of this Act in the contingency reserve of a discontinued plan, such amounts shall be disposed of in accordance with section 8909(e) of title 5, United States Code, as amended by this subsection, by --

(A) the deadline set forth in section 8909(e) of such title (as so amended); or

(B) if later, the end of the 6-month period beginning on such date of enactment.

SEC. 7. MAXIMUM PHYSICIANS COMPARABILITY ALLOWANCE PAYABLE.

(a) IN GENERAL. -- Paragraph (2) of section 5948(a) of title 5, United States Code, is amended by striking "$20,000" and inserting "$30,000".

(b) AUTHORITY TO MODIFY EXISTING AGREEMENTS. --

(1) IN GENERAL. -- Any service agreement under section 5948 of title 5, United States Code, which is in effect on the date of enactment of this Act may, with respect to any period of service remaining in such agreement, be modified based on the amendment made by subsection (a).

(2) LIMITATION. -- A modification taking effect under this subsection in any year shall not cause an allowance to be increased to a rate which, if applied throughout such year, would cause the limitation under section 5948(a)(2) of such title (as amended by this section), or any other applicable limitation, to be exceeded.

(c) RULE OF CONSTRUCTION. -- Nothing in this section shall be considered to authorize additional or supplemental appropriations for the fiscal year in which occurs the date of enactment of this Act.

SEC. 8. CLARIFICATION RELATING TO SECTION 8902(k).

Section 8902(k) of title 5, United States Code, is amended --

(1) by redesignating paragraph (2) as paragraph (3); and

(2) by inserting after paragraph (1) the following:

"(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other than a practice or profession listed in paragraph (1), if such provider is licensed or certified as such under Federal or State law.".

I. SUMMARY OF LEGISLATION

H.R. 1836, as amended by the Committee, amends several provisions in title 5, United States Code. It provides the Office of Personnel Management (OPM) additional tools to fight waste, fraud, and abuse in the Federal Employees Health Benefits (FEHB) program. With these tools, OPM will be able to deal swiftly with health care providers who try to defraud the FEHB program. OPM will be better equipped to bar health care providers who engage in misconduct from participating in the FEHB program or to impose monetary penalties on them. The bill also provides that an association of organizations may underwrite health care plans in the FEHB program, and it broadens the current statutory language preempting State insurance laws.

In addition, the bill permits certain employees of the Federal Deposit Insurance Corporation (FDIC) and the Federal Reserve Board (Fed) to participate in the FEHB program, and it requires OPM to encourage carriers who contract with third parties to obtain discounts from health care providers to seek assurances that the conditions for the discounts are fully disclosed to such providers. It also establishes statutory requirements for readmitting health care plans sponsored by employee organizations that have previously discontinued participation in the FEHB program. Under current law, when a health care plan discontinues participation in the FEHB program, OPM must credit that plans remaining contingency reserves to those plans that remained in the FEHB program in the contract year after the discontinuance. This bill requires OPM to complete the distribution by the end of the second contract year after the plan is discontinued.

The maximum amount of the physicians comparability allowance under 5 U.S.C. § 5948 is increased from $20,000 to $30,000.

The bill also amends 5 U.S.C. § 8902(k) to explicitly permit carriers to provide for direct access and direct

payments to licensed health care providers who are not currently enumerated in the statute.

II. Background and Need for the Legislation

Section 1

H.R. 1836 was introduced by Mr. Burton of Indiana to strengthen the integrity and standards of the FEHB program and allow it to maintain its reputation as a high quality and cost-effective program. The FEHB program is the largest employer-sponsored health insurance system in the country. In 1997, the $16 billion FEHB program will insure more than nine million Federal employees, retirees, and their dependents. Partial portability, the absence of preexisting condition limitations, and an annual open enrollment period are facets of the FEHB program that make it an extremely attractive health care system. The programs market orientation has effectively contained costs through private sector competition with limited governmental intervention. The program is often cited as a model of efficiency and effectiveness that the private sector and the public sector should attempt to replicate. This bill will improve the program and its performance without changing the market principles that are the key to its success.

Section 2

Section 2 of this bill addresses the debarment of health care providers engaging in fraudulent practices. This provision would strengthen the ability of OPM to bar health care providers who engage in professional and or financial misconduct from participating in the FEHB program or to impose monetary penalties on them. Under this bill, the administrative sanctions authority would conform more closely with provisions of Medicare law. The parallels between these provisions and Medicare law should benefit not only OPM, but also carriers and health care providers, who are already familiar with interpretations and practices under similar Medicare provisions.

In addition, this bill streamlines the debarment process by generally permitting OPM to debar a provider before a hearing is held. However, upon request, the provider would be entitled to an administrative hearing after an adverse determination is made if the provider shows that due process rights were not previously afforded with respect to any finding of fact which is relied upon as a cause for the adverse determination. The hearing will be held before a hearing officer who shall be designated by the Director of OPM and conducted without regard to the requirements of subchapter II of chapter 5 and chapter 7 of title 5, United States Code. Judicial review shall lie with the United States District Court for the District of Columbia or other appropriate district, rather than, as under current law, with the United States Court of Appeals for the Federal Circuit.

Under current law, OPM is permitted to debar health care providers on certain grounds, but it is not required to do so. This bill makes debarment mandatory if a health care provider is convicted of certain criminal offenses or is currently debarred, suspended or otherwise excluded from any procurement or nonprocurement activity within the meaning of section 2455 of the Federal Acquisition Streamlining Act of 1994.

OPM retains its existing authority to debar health care providers on grounds relating to professional licensing, and this bill adds four additional grounds for permissive debarment, including the determination that a provider has charged substantially more than the providers customary charge for health care services or supplies without good cause, or has charged for substandard or medically unnecessary health care services or supplies. The determination that a service or supply is medically unnecessary must be made by trained reviewers on the basis of written medical protocols developed by physicians. In the event such a determination cannot be made based on such protocols, OPM must consult a physician in an appropriate specialty. These trained reviewers may be employees of

OPM, other appropriately trained Federal employees, or contractors.

Existing law does not mandate a minimum period of debarment. This bill, however, requires that providers convicted under Federal or State law of certain offense must be debarred for at least 3 years.

Under current law, OPM, in consultation with the Attorney General, may impose a civil monetary penalty of up to $10,000 on a health care provider guilty of certain misconduct. This bill modifies the grounds upon which OPM may assess such penalties. OPM's authority to impose a monetary penalty on health care providers for excessive charges or charges for substandard or medically unnecessary services or supplies is deleted. (That misconduct becomes, instead, grounds for permissive debarment.) But it is given additional authority to impose a civil penalty for charges exceeding Medicare limitations in violation of 5 U.S.C. § 8904(b) or charging for items or services provided during a period of debarment.

These modifications of OPM's authority to debar health care providers and impose monetary penalties upon them will strengthen OPM's ability to protect the FEHB program -- and the employees and retirees who depend upon it -- from fraudulent or abusive practices that drive up health care costs and premiums.

Section 3

The bill amends the definition of "carrier" and the description of the government-wide Service Benefit Plan under current law. The revised definition makes clear that an association of organizations, or other entities, may be the carrier for any health benefits plan in the FEHB program. The new description makes clear that the carrier for the government-wide Service Benefit Plan need not contract with underwriting affiliates licensed in all of the States and the District of Columbia. Indeed, although the government-wide Service Benefit Plan historically has been underwritten by all of the affiliates of the sponsoring association, the

withdrawal of an affiliate in a State would not affect the sponsoring associations ability to continue offering the plan in that State.

In addition, this bill broadens the preemption provisions in current law to strengthen the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live. This change will strengthen the case for trying FEHB program claims disputes in Federal courts rather than State courts. It will also prevent carriers cost-cutting initiatives from being frustrated by State laws. For example, a carrier's effort to establish a preferred provider organization (PPO) across the country would not be jeopardized by State-mandated "any willing provider" statutes.

* * * * * * *

V. EXPLANATION OF THE BILL AS REPORTED SECTION-BY-SECTION

* * * * * * *

Subsection (a)(7) amends provisions relating to the notice and hearing requirements and to judicial review. Under current law, OPM may not debar a provider or impose a monetary penalty until after the provider has been given written notice and an opportunity for a hearing on the record, and any person affected by OPM's final adverse decision may obtain review in the United States Court of Appeals for the Federal Circuit. This subsection provides that a provider subject to an adverse determination by OPM is entitled to reasonable notice and an opportunity to request a hearing of record. OPM is required to grant a request for a hearing upon a showing that due process rights previously have not been afforded for any finding of fact relied upon as a cause for an adverse determination. The hearing is not subject to subchapter II of chapter 5 or chapter 7 of title 5, which relate to administrative procedures and judicial review. Judicial review is available in the United States District Court for the District of Columbia, or for the district in which the plaintiff

resides or has his or her principal place of business. The district court may not set aside or remand an OPM decision unless there is not substantial evidence on the record, taken as a whole, to support the findings by OPM or unless OPM has abused its discretion.

* * * * * * *

XVI. CHANGES IN EXISTING LAW

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in the existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

* * * * * * *

Subsection (c) amends section 8902(m) to broaden the preemption of State and local laws with respect to health care contracts under the FEHB program. This amendment confirms the intent of Congress (1) that FEHB program contract terms which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) completely displace State or local law relating to health insurance or plans and (2) that this preemption authority applies to FEHB program plan contract terms which relate to the provision of benefits or coverage, including managed care programs.

* * * * * * *

§ 8902. Contracting authority

* * * * * * *

[(m)(1) The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health

insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.]

(m)(1) The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

* * * * * * * *

§ 8902a. Debarment and other sanctions

* * * * * * * *

(h)(2) Any provider adversely affected by a final decision under paragraph (1) made after a hearing to which such provider was a party may seek review of such decision in the United States District Court for the District of Columbia or for the district in which the plaintiff resides or has his or her principal place of business by filing a notice of appeal in such court within 60 days after the date the decision is issued, and by simultaneously sending copies of such notice by certified mail to the Director of the Office and to the Attorney General. In answer to the appeal, the Director of the Office shall promptly file in such court a certified copy of the transcript of the record, if the Office conducted a hearing, and other evidence upon which the findings and decision complained of are based. The court shall have power to enter, upon the pleadings and evidence of record, a judgment affirming, modifying, or setting aside, in whole or in part, the decision of the Office, with or without remanding the case for a rehearing. The district court shall not set aside or remand the decision of the Office unless there is not substantial evidence on the record, taken as whole, to support the findings by the Office of a cause for action under this section or unless action taken by the Office constitutes an abuse of discretion.

[IMAGE]

December 17, 1999

WHITMAN BREED ABBOTT & MORGAN LLP
200 Park Avenue
New York, New York 10166

Attention: David M. Berger

RE: Our client: JOSEPH McVEIGH, DENISE McVEIGH
Your client: EMPIRE BLUE CROSS/BLUE SHIELD

Dear Mr. Berger:

I am writing in response to your letter of November 17, 1999 regarding the right of subrogation of your client for medical payments. Please excuse my delay in responding.

Enclosed is a copy of the Summons & Verified Complaint in our action. Also enclosed is a copy of a recent motion so that you can see the present status of the two consolidated cases. The motion also provides the attorneys representing all parties in these cases and court information.

While we certainly understand EBCBS's right of subrogation and are providing information in an effort to cooperate with you and EBCBS in this regard, it is our understanding of the current law that such right of

subrogation does not constitute a lien against a recovery in a personal injury case as you state in your letter.

If you have some authority for the assertion of a lien, I would ask that you provide such authority so that it can be reviewed and our file properly documented.

The personal injury case is still pending in Supreme Court, Suffolk County and should be next scheduled with Justice Bromley Hall for a compliance/certification conference.

Very truly yours,

/s/
VICTOR A. CARR

SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF SUFFOLK

----------x

JOSEPH FINN and PATRICIA FINN,

Plaintiffs,

- against -

Index No.
11335/98

TOWN OF SOUTHAMPTON, GREGORY G. L'HOMMEDIEU and CHRIS G. L'HOMMEDIEU,

Defendants.

----------x

DENISE FINN McVEIGH, As Administratrix of the Estate of JOSEPH E. McVEIGH, deceased, and DENISE FINN McVEIGH, Individually,

Plaintiff,

- against -

TOWN OF SOUTHAMPTON, GREGORY G. L'HOMMEDIEU, CHRIS G. L'HOMMEDIEU, MERCEDES-BENZ CREDIT CORPORATION, and JOSEPH FINN,

Defendants.

----------x

TOWN OF SOUTHAMPTON,

Third-Party Plaintiff,

- against -

Index No.
22/233

ROY CLARK INVESTIGATION & SECURITY SERVICE, LTD.,

Third-Party Defendant.

----------x

MERCEDES-BENZ CREDIT CORPORATION,

Second/Third Party Plaintiff,

- against -

Index No.
22/275

ROY CLARK INVESTIGATION & SECURITY SERVICE, LTD.

Second/Third Party Defendant.

----------x

March 19, 2003
Riverhead, New York

Before:

HON. EDWARD D. BURKE, Justice.

Appearances: [omitted for printing]

William J. Fugelsang, C.S.R.
Official Court Reporter

MR. STOCK: Would you swear in the plaintiffs, please.

JOSEPH J. FINN, a plaintiff herein, of 52 Argonne Road East, Hampton Bays, New York, being duly sworn, testified as follows:

EXAMINATION BY

MR. DOWNES:

Q Joe, you understand that there is a settlement offer in the claim brought by yourself and your wife with respect to the action against the Town of Southampton, Chris L'Hommedieu and Greg L'Hommedieu, is that correct?

A Yes.

Q And you understand, having spoken with myself and my office, that there has been a gross settlement offer of $275,000 in this matter?

A Correct.

Q And of that settlement the L'Hommedieu defendants, and/or their carrier, are going to pay the sum of $250,000, and on behalf of the town of Southampton a payment of $25,000 is going to be made, do you understand?

A Yes.

Q Do you understand that by giving your consent to the settlement of this action today, this cause of action arising out of the automobile accident of May 19, 1997 will be closed, and you cannot come back to court with respect to the injuries as a result of this particular accident?

A I understand.

Q And you have had an opportunity to speak with your wife, Frances, regarding this proposed settlement, right?

A Yes.

Q And, of course, she is also a party to this action, correct?

A Yes.

Q And at the present time do you speak with the consent of Frances with respect to this settlement?

A Yes.

Q And is it your desire to accept the settlement offer that has been proposed in this action, that is, the payment of the $275,000?

A Yes.

Q And do you also understand that out of that gross settlement of $275,000 there are attorneys' fees that must be satisfied, and disbursements associated with the prosecution of this case?

A Yes, I understand.

Q And is it your desire to accept the settlement that has been proposed in this action?

A Yes, I do.

Q And, of course, on behalf of your wife you are accepting this of your own fee [sic] will, is that correct?

A Yes.

Q Do you also understand that we have to sign general releases and a stipulation of discontinuance and serve that upon the attorneys for the respective defendants in this particular action?

A Yes.

Q And upon receipt of those papers they will make payment to you, do you understand that?

A Right.

MR. DOWNES: It is hereby stipulated by and between the attorney for the respective parties herein that this action, specifically the action of Joseph Finn and Frances Finn against the Town of Southampton, Gregory G. L'Hommedieu and Chris G. L'Hommedieu, is hereby settled in the sum of $275,000, and upon payment of such consideration the action will be discontinued with prejudice, and without further costs to any party.

It is also my understanding that upon receipt of proper release papers and stipulations of discontinuance, on behalf of the defendants L'Hommedieu payment will be made within 60 days time, and with respect to the Town of Southampton payment will be made on or before the expiration of 90 days.

THE COURT: Mr. Finn, have you had ample time to discuss this matter in full with your attorney?

MR. FINN: Yes, sir.

THE COURT: And you are satisfied with the services rendered by your attorneys?

MR. FINN: Yes.

THE COURT: And you understand that you can't come back to court on this claim after this settlement?

MR. FINN: I understand.

THE COURT: All right.

MR. STOCK: Off the record a minute.

(Off-record discussion.)

MR. STOCK: It is hereby stipulated and agreed by and between counsel for the plaintiff and the defendants in action number two, entitled Denise Finn McVeigh, as Administratrix of the Estate of Joseph McVeigh, deceased, and Denise Finn McVeigh, plaintiffs, against the Town of Southampton, et al, that that action is settled for the total sum of 3,175,000.

The One Beacon Insurance Company, on behalf of Joseph Finn, will pay within 30 days after presentation to their counsel, Renny Way, of a wrongful death compromise order, and a general release from all of the plaintiffs, as well as stipulations of discontinuance, the sum of $1,500,000.

The defendant Mercedes-Benz Credit Corporation will, upon presentation to their counsel, Lester, Schwab,

Katz and Dwyer of a wrongful death compromise order, general releases and stipulations of discontinuance, pay within 30 days the sum of $1,100,000, which will be structured to some extent.

The defendant Gregory G. L'Hommedieu and/or the One Beacon Insurance Company, on behalf of the defendants Gregory G. L'Hommedieu and Chris G. L'Hommedieu, will pay the sum of $232,000 upon presentation to counsel-

MR. ALEDORT: Wait, that's not correct. Off the record.

(Off-record discussion.)

MR. STOCK: The insurers for Gregory G. L'Hommedieu and Chris G. L'Hommedieu will pay on their behalf, upon presentation to their attorneys, Scibillia, Polacco and Aledort of a wrongful death compromise order, general releases and stipulations of discontinuance, within 30 days, the sum of $325,000.

The defendant Town of Southampton will pay the sum of $250,000 upon presentation of a wrongful death compromise order, general releases and stipulations of discontinuance to their counsel, Kelly Rode and Kelly, within 30 days.

The defendant and Third-Party plaintiff Town of Southampton and Mercedes-Benz Credit Corporation, shall provide the Third-Party defendant Roy Clark Investigation and Security Service, Ltd. with a general release and stipulations of discontinuance, with prejudice.

As everyone knows, there are four causes of action involved in this case: a claim for personal injury by Denise Finn, a claim for loss of consortium by Denise Finn, a claim on behalf of the Estate of Joseph McVeigh for pain and suffering, and a wrongful death claim on behalf of his distributees.

The plaintiffs reserve the right, subject to the Surrogate of New York County, to assign to those particular causes of action that portion of the total settlement that it deems proper, and the Surrogate approves.

The defendants have indicated, and indicate herein, that they have no interest in that, and consent to however that is distributed.

The plaintiff herein agrees and represents to defendants that there are no liens on the recovery in this action, and that in the event that any liens should appear, the plaintiff will indemnify the defendants and defendants' counsel from any claims by by [sic] any lien holder not known to us.

The plaintiffs also represents that they are aware that there is a claim of lien by Empire Blue Cross/Blue Shield of $175,000 approximately, and we dispute that lien. You have been advised of that.

We have agreed with counsel for the alleged lien holder to hold in escrow the sum of $100,000 until there is a resolution of that lien holder's claim. The lien holder is present and joins in this stipulation, and agrees that they will bring any claim that they intend to bring within thirty days of this stipulation or be time barred from doing so.

The plaintiff reserves to itself the right to bring an Order to Show Cause in this court to have this court resolve that issue should it deem that to be in its best interests. The alleged lien holder and myself disagree on whether that's appropriate in terms of the jurisdiction of this court, and we agree that the courts will have to decide that as being an open issue.

We further agree that the extent of the lien holder's lien, if any, is still in issue, and that they are not waiving any portion of their claim at this time, they are merely

agreeing that they will not bring any claim against anyone else involved in this case to assert their lien, other than the estate of Joseph McVeigh.

The third-party action an [sic] cross claims are as well discontinued without interest, costs or disbursements to any party.

The settlement that we have placed upon the record is subject to the approval of the Surrogate of New York County in the submission of the wrongrul [sic] death compromise order.

Off the record.

(Off-record discussion)

MR STOCK: The Surrogate of New York County has jurisdiction and will have to approve the wrongful death in the survivor's action. He has no jurisdiction to hear or approve Denise Finn's personal injury action or her claim for loss of consortium.

In addition, the general release that we provide to Mercedes-Benz Corporation will also release Allion Insurance Corporation.

Mr. Bastible is present on behalf of Morrison, Cohen, Singer and Weinstein, LLP, and, sir, do you agree to the terms of the stipulation as it applies to your claim of lien, and you have authority to do so?

MR. BASTIBLE: I do have authority and I do stipulate, having in mind though the issue as to which court may have proper jurisdiction.

MR. STOCK: But as to the remainder of the stipulation you agree?

MR. BASTIBLE: Yes, I do.

MR. STOCK: And Mr. Bastible's firm has written letters to all the law firms involved in the case indicating that they intended to bring claims against those law firms

and their clients in the event that the lien was not paid, or this alleged lien was not paid today.

Counsel, you withdraw that, I assume, and agree that you are not going to bring a claim against any of the other parties involved in this case, other than the estate of Joseph McVeigh, or my office as the escrow holder?

MR. BASTIBLE: Certainly not, no.

MR. DORRY: None of the defendants or their law firms?

MR. BASTIBLE: That is correct.

MR. STOCK: And with respect to the settlement from Allion Insurance, on behalf of the Mercedes-Benz Credit Corporation, the plaintiffs herein are agreeing to structure that portion of that settlement which is going to be distributed, again subject to the approval of the Surrogate as to the decedent infant Brendan McVeigh, at least that amount.

I have nothing further.

MR. DORRY: With respect to the third-party plaintiff Mercedes-Benz Credit Corporation against Roy Clark, I have spoken with them and we are just going to send a stipulation of discontinuance with prejudice.

MR. STOCK: Now Denise, you have heard the stipulation of settlement as put on the record, is that correct?

DENISE FINN MC VEIGH: Yes, I have.

MR. STOCK: And we have had an opportunity over the last week or so to discuss the settlement that we are talking about and that you have heard put on the record?

DENISE FINN MC VEIGH: Yes.

MR. STOCK: And are you satisfied with the settlement?

DENISE FINN MC VEIGH: Yes.

MR. STOCK: And you understand it?

DENISE FINN MC VEIGH: Yes.

MR. STOCK: And you have had time to talk to me about it, and I have explained it all to you?

DENISE FINN MC VEIGH: Yes.

MR. STOCK: And you understand that once we agree to settle this today, and the Surrogate approves the settlement, that we can never come back to court for the injuries that occurred to Joe or yourself as the result of the accident that took place on May 9, 1997?

DENISE FINN MC VEIGH: I understand.

MR. STOCK: And knowing all of that you are agreeable to the settlement?

DENISE FINN MC VEIGH: Yes.

MR. STOCK: And you understand that out of the settlement sum will come the fees and disbursements, attorney's fees and disbursements?

DENISE FINN MC VEIGH: Yes.

MR. STOCK: I have nothing further.

MR. HOEFLING: On behalf of Joe Finn there was a representation that there are no liens, but if there are, we are being held harmless, our law firms and our clients and our carriers? I didn't hear that, so I would seek to add that to the stipulation.

THE COURT: Is that so stipulated on behalf of the plaintiff?

MR. DOWNES: As counsel for Joe Finn, my understanding is that there are none; I have not been informed of any liens relative to the claim brought by Mr. Finn with respect to medical or anything.

If there are claims for liens or medical services, plaintiffs will hold the defendants and their counsel harmless with respect to such claims.

MR. STOCK: So stipulated?

MR. DOWNES: So stipulated.

MR. AALVARADO: So stipulated.

MR. DORRY: So stipulated.

MR. WAY: So stipulated.

MR. HOEFLING: So stipulated.

MR. ALDORT: So stipulated.

THE COURT: Submit your papers, counsel.

MR. STOCK: And thank you for your assistance, your Honor.

(The matter thereupon concluded.)

- - -

CERTIFICATION is given that the foregoing is a true and complete transcript of the stipulation of settlement as placed upon the record in the within matter.

/s/

Official Court Reporter

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

EMPIRE HEALTHCHOICE ASSURANCE, INC.
d/b/a/ Empire Blue Cross Blue Shield,

Plaintiff,

v.

DENISE FINN MCVEIGH, as Administratrix of the Estate of Joseph E. McVeigh,

Defendant.

COMPLAINT
(Civil Action No. 03CV2728)

Plaintiff Empire HealthChoice Assurance, Inc. d/b/a Empire Blue Cross Blue Shield ("Empire") brings this complaint against Defendant Denise Finn McVeigh, administratrix of the estate of Joseph E. McVeigh, and respectfully states as follows:

NATURE OF ACTION

1. Joseph E. McVeigh ("Decedent") was enrolled in the Service Benefit Plan, one of the federal government's nation-wide health benefits plans for federal employees and their dependents. The Service Benefit Plan was created by federal government contract between the United States Office of Personnel Management ("OPM") and the Blue Cross and Blue Shield Association ("BCBSA"), pursuant to the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C.

§§ 8901-8914. Empire is the Blue Cross and Blue Shield entity that administers the Service Benefit Plan in New York

2. Empire seeks to recover benefits it paid to the Decedent for the treatment of injuries sustained by the Decedent, because the Decedent's estate, administered by Defendant Denise Finn McVeigh, has made a recovery on his behalf in connection with those injuries through settlement with alleged third-party tortfeasors. Plaintiff is entitled to reimbursement under the unambiguous terms of the Service Benefit Plan's subrogation and right-of-recovery provisions. Accordingly, Empire brings this action to enforce the terms of one of the federal government's health benefits plans and to obtain the relief that those terms warrant.

3. The money originally paid by Empire for Decedent's benefits came from premiums collected by OPM for enrollment in the Service Benefit Plan. The U.S. government contributes the majority of these funds, which are held in the federal Treasury. The recovery that Plaintiff makes in this case will inure to the benefit of the United States because it will result in the return to the U.S. Treasury of money earlier expended by the United States on benefits. Accordingly, Plaintiff's recovery in this case directly affects the United States' interests. Under BCBSA's contract with OPM, Plaintiff has an obligation to seek reimbursement of the federal government's funds where the enrollee has recovered from a third party.

JURISDICTION

4. This action is founded on the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-8914; on federal contracts and regulations established pursuant to FEHBA; and on federal common law. It involves the Service Benefit Plan, a health benefits plan established pursuant to FEHBA. Plaintiff's cause of action for reimbursement turns on the construction and application of FEHBA, federal contract provisions, federal regulations, and

federal common law. This Court, therefore, has jurisdiction over this action pursuant to 28 U.S.C. § 1331.

VENUE

5. Venue lies in the Southern District of New York pursuant to 28 U.S.C. § 1391(b).

PARTIES

6. FEHBA gives OPM the responsibility for establishing and regulating federal health benefits plans for federal employees and their dependents. Pursuant to this statutory mandate, OPM entered a federal government contract with BCBSA to establish the Service Benefit Plan. See generally 1996 Contract between OPM and the Association and subsequent amendments (Exh. A); 2002 Contract between OPM and the Association (Exh. B). The Service Benefit Plan is underwritten by local Blue Cross and Blue Shield companies, which administer the Service Benefit Plan in their localities. Empire is the local Blue Cross and Blue Shield company that administers the Service Benefit Plan in New York.

7. Defendant Denise Finn McVeigh is administratrix of the Decedent's estate; at all times relevant to this action, the Decedent was enrolled in the Service Benefit Plan. The estate has its situs in this District and Ms. McVeigh resides in this District.

FACTS

8. Upon information and belief, the Decedent suffered injuries in 1997 for which he received medical treatment.

9. Beginning in 1997, the Decedent and his health care providers submitted numerous claims to Empire for coverage of medical treatment relating to Decedent's injuries.

10. Between 1997 and 2001, Empire paid $157,309.06 in benefits for medical treatment relating to Decedent's injuries. This represents the amount of benefits to which the

Decedent was entitled under the terms of the Service Benefit Plan.

11. Upon information and belief, Decedent died on November 9, 2001 from his injuries.

12. In addition to Decedent's claims for benefits from Empire, Defendant Denise Finn McVeigh filed a tort action in state court on the Decedent's behalf and on her own behalf against the third parties that allegedly caused the Decedent's injuries. The minor child of the Decedent and Ms. McVeigh also filed an action in state court on the minor child's behalf against the third parties.

12. The Service Benefit Plan contains a subrogation and right-of-recovery provision. Pursuant to the Service Benefit Plan, if the local administering Blue Cross and Blue Shield company pays benefits to an enrollee for treatment necessitated by an injury and the enrollee later recovers compensation from a third party in connection with that injury, then the enrollee must reimburse the local administering Blue Cross and Blue Shield company, in this case Empire, for the amount of benefits paid. The subrogation and right-of-recovery provision provides:

> This subrogation and right of recovery provision applies when you or your dependent are sick or injured as a result of the act or omission of another person or party. The Plan has the right to recover payments the Plan has made to you or your dependent from a third party or third party's insurer because of illness or injury caused by a third party. In addition to its right of recovery, the Plan is subrogated to you and your dependent's present and future claims against a third party. Third party means another person or organization.
>
> If you or your covered dependent suffer an injury or illness through the act or omission of another, you and your dependent agree: 1) to reimburse the Plan for benefits paid by the Plan in an amount not to

exceed the amount of the recovery; and 2) that the Plan be subrogated to your (or your dependent's) rights to the extent of the benefits paid, including the right to bring suit. All recoveries from a third party (whether by lawsuit, settlement, or otherwise) must be used to reimburse the Plan for benefits paid. The Plan's share of the recovery will not be reduced because you or your dependent do not receive the full amount of damages claimed, unless the Plan agrees in writing to a reduction.

When you or your dependent make a claim against a third party or the third party's insurer as a result of an injury or illness for which that third party is legally responsible, the Plan shall have a lien on the proceeds of that claim in order to reimburse itself to the full amount of benefits it is called upon to pay. The Plan's lien will apply to any and all recoveries for such claim whether by court order or out-of-court settlement.

If you or your dependent are injured because of a third party's action or omission: 1) the Plan will pay benefits for that injury subject to the conditions that you and your dependent a) do not take any action that would prejudice the Plan's ability to recover benefits, and b) will cooperate in doing what is reasonably necessary to assist the Plan in any recovery; 2) the Plan's right of reimbursement extends only to the amount of Plan benefits paid or to be paid because of the injury; and 3) the Plan may insist upon an assignment of the proceeds of the claim or right of action against the third party and may withhold payment of benefits otherwise due until the assignment is provided.

You are required to notify the Plan promptly of any third party claim that you may have for damages for which the Plan has paid or may pay benefits. In addition, you are required to notify the Plan of any

> recovery, whether in or out of court, that you or your dependent obtain and to reimburse the Plan to the extent of benefits paid by the Plan. Any reduction of the Plan's claim for payment of attorney's fees or costs associated with the claim is subject to prior approval by the Plan.

1997 Statement of Benefits for the Service Benefit Plan at 12 (Exh. C); accord 1998 Statement of Benefits for the Service Benefit Plan at 12 (Exhibit D); 1999 Statement of Benefits for the Service Benefit Plan at 12 (Exh. E); 2000 Statement of Benefits for the Service Benefit Plan at 12 (Exh. F); 2001 Statement of Benefits for the Service Benefit Plan at 86 (Exh. G).

14. In March 2003, Empire learned that Ms. McVeigh had agreed to settle her claims on behalf of the Decedent and herself against the alleged tortfeasors. On March 11, 2003 Empire notified her, through her counsel Defendant Thomas J. Stock, that it had a lien against the estate's portion of the tort settlement in the amount of $157,309.06. *See* Letter from Howard F. Wolfson to Thomas J. Stock at 2 (Mar. 11, 2003) (Exh. H).

15. Defendant responded by disputing the existence of Empire's lien. *See* Letter Thomas J. Stock to Howard S. Wolfson (Mar. 13, 2003) (Exh. I). Mr. Stock has also stated that Empire "never has and never will have a lien on the recovery in [the tort] action." Letter from Thomas J. Stock to Alfredo J. Alvarado at 1 (Mar. 7, 2003) (Exh. J).

16. In a hearing conducted March 19, 2003 in connection with the settlement, Ms. McVeigh and the other parties to the tort actions stipulated to settlement for the sum total of $3,175,000 for both the suit brought by her on the estate's behalf and individually and the suit brought by her minor child, with the respective shares for each claimant imminently to be determined.

17. At the hearing, in light of the disagreement between them and Empire, Ms. McVeigh, through her counsel, agreed

to hold $100,000 of the settlement funds in escrow pending resolution of Empire's claims for enforcement of its lien. The escrowing of that amount was not to be in prejudice of Empire's right to recover the full amount of $157,309.06 to which it is entitled. Empire agreed that it would file a lawsuit to resolve its right to reimbursement within thirty days from the date of the settlement hearing.

COUNT I
(Breach of Obligations under FEHBA Plan)

18. Plaintiff repeats and re-alleges paragraphs 1-17 as if fully set forth herein.

19. Defendant's refusal to reimburse Empire from the settlement proceeds for the amount of benefits paid by Empire violates the express terms of the Service Benefit Plan. Under the provisions of the Service Benefit Plan, Defendant -- on the estate's behalf -- is obligated to reimburse Empire for the full amount of benefits the Decedent received, upon the estate's recovery from the third parties associated with Decedent's injuries. Defendant has flatly rejected Empire's assertion of a lien and refused to pay back any amounts the Decedent received in benefits. Accordingly, Defendant has breached and imminently will further breach obligations under the Service Benefit Plan, and Plaintiff is entitled to relief.

COUNT II
(Declaratory Judgment)

20. Plaintiff repeats and re-alleges paragraphs 1-19 as if fully set forth herein.

21. Empire has asked Defendant for reimbursement from the settlement proceeds for the amount of benefits paid by Empire on behalf of the Decedent for treatment of the Decedent's injuries.

22. Despite Empire's demand, Defendant has refused to reimburse Empire for the amount of benefits paid by Empire

on behalf of the Decedent for treatment of the Decedent's injuries.

23. As a result, an actual and justiciable controversy has arisen between Empire and Defendant as to whether Empire had and continues to have the right to reimbursement of the amount of benefits paid by Empire on behalf of the Decedent for treatment of the Decedent's injuries, pursuant to the express terms of the Service Benefit Plan.

24. Empire is entitled to a judgment declaring that, pursuant to the express terms of the Service Benefit Plan, as well as FEHBA, its implementing federal regulations, and federal common law, it has the right to reimbursement from Defendant for the amount of benefits paid by Empire on behalf of the Decedent for treatment of the Decedent's injuries.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully requests that this Court:

A. Declare that Empire has a lien in the amount of $157,309.06 against the settlement proceeds of Defendant Denise Finn McVeigh relating to her state court claim on behalf of Decedent's estate against the third parties alleged to have caused Decedent's injuries;

B. Enter judgment against Defendant Denise Finn McVeigh, as administratrix of the Decedent's estate, in the amount of $157,309.06 to reimburse Empire for benefits paid for medical care relating to Decedent's injuries;

C. Order Defendant to disburse to Empire the amount of $100,000 currently escrowed for the purpose of protecting Empire's lien, as partial reimbursement for the benefits Empire paid to the Decedent;

D. Order Defendant to pay Empire an additional amount of $57,309.06 upon receipt of said amount in the settlement of Defendant Denise Finn McVeigh's state court

claim on the estate's behalf against the third parties alleged to have caused Decedent's injuries;

E. Grant such other and further relief as this Court deems necessary and proper.

Respectfully submitted,

EMPIRE BLUE CROSS & BLUE SHIELD,

By: /s/_____

Kieran X. Bastible (KXB9300)
MORRISON COHEN
SINGER & WEINSTEIN, LLP
750 Lexington Avenue
New York, NY 10022
Telephone: 212-735-8600
Facsimile: 212-735-8708

Counsel for Plaintiff

Of Counsel:
Anthony F. Shelley
MILLER & CHEVALIER CHARTERED
655 15th Street, N.W.
Washington, D.C. 20005
Telephone: 202-626-5924
Facsimile: 202-628-0858

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

EMPIRE HEALTHCHOICE ASSURANCE, INC.
d/b/a/ Empire Blue Cross Blue Shield,

Plaintiff,

v.

DENISE FINN MCVEIGH, as Administratrix of the Estate of Joseph E. McVeigh,

Defendant.

DECLARATION OF CLINTON SHATZER
(Civil Action No. 03CV2728(DJC))

CLINTON SHATZER, declares the following to be true under penalties of perjury:

1. I am the Senior Program Manager, Financial Policy for the Blue Cross and Blue Shield Association ("BCBSA") Federal Employee Program. I have held this position for approximately two years. I have been employed by BCBSA for 19 years.

2. BCBSA, a nonprofit membership organization, owns and licenses the Blue Cross and Blue Shield service names and service marks. Forty-three individual Blue Cross and Blue Shield companies nationwide are its members. They offer

health care benefits throughout the United States and administer the payment of health benefits claims.

3. BCBSA, on behalf of participating Blue Cross and Blue Shield companies, has entered into a contract with the U.S. Office of Personnel Management ("OPM"), to offer the Government-wide Service Benefit Plan ("Service Benefit Plan") to federal employees and annuitants. Under that contract, the local Blue Cross and Blue Shield companies administer benefits for and underwrite the Service Benefit Plan in their individual localities.

4. Service Benefit Plan premiums are paid by the government and federal employees and retirees according to a formula set forth in the Federal Employees Health Benefits Act. The government typically pays approximately 72% of the premium, with the federal employees and retirees paying the remainder. The premiums are collected by the federal payroll offices and forwarded to a specially-created fund in the U.S. Treasury called the Employees Health Benefits Fund.

5. Blue Cross and Blue Shield companies pay health care providers and enrollees for services covered by the Service Benefit Plan. They are in turn then paid from Service Benefit Plan premiums using a special Letter of Credit Account ("LOCA") set up in the U.S. Treasury.

6. Premium payments collected for the Service Benefit Plan are made available in the LOCA for withdrawal by the Blue Cross and Blue Shield companies. They withdraw funds from the LOCA on a "checks-presented basis." This means that their withdrawals are delayed until the checks they have issued for FEHBA Program disbursements are presented to their banks for payment.

7. Each Blue Cross and Blue Shield company returns subrogation and reimbursement funds to the Employees Health Benefits Fund in the U.S. Treasury by reducing their LOCA withdrawals. For example, assume that a Blue Cross and Blue Shield company has $100,000 in checks presented

to its bank for payment from providers, and so is entitled to draw down $100,000 from the Service Benefit Plan's LOCA in the Federal Treasury. It also, however, has $10,000 in subrogation or reimbursement recoveries that it needs to return to the Federal Treasury account. In such a case, it would drawn [sic] down $90,000, thus effectively returning the $10,000 in subrogation or reimbursement funds to the LOCA.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on June 19, 2003.

/s/
Clinton Shatzer

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

EMPIRE HEALTHCHOICE ASSURANCE, INC. d/b/a EMPIRE BLUE CROSS BLUE SHIELD,	)	
Plaintiff,	)	
v.	)	Civil Action No. 03-CV-2728 (DC)
DENISE FINN McVEIGH, as Administratrix of the Estate of JOSEPH E. McVEIGH,	)	
Defendant.	)	

EMPIRE'S RESPONSE TO DEFENDANT'S STATEMENT OF MATERIAL FACTS

In response to Defendant's Statement of Material Facts, Plaintiff Empire HealthChoice Assurance, Inc., d/b/a Empire Blue Cross Blue Shield ("Empire") does not dispute paragraphs 1-3. Empire does not admit the statement in paragraph 4, but notes that it lacks sufficient knowledge regarding the statement either to admit or dispute it. In any event, none of the alleged facts stated by Defendant as material and undisputed supports either dismissal or summary judgment in Defendant's favor in this case.

Respectfully submitted,

EMPIRE BLUE CROSS &
BLUE SHIELD

By: /s/_____

Kieran X. Bastible
MORRISON COHEN
SINGER & WEINSTEIN, LLP
750 Lexington Avenue
New York, NY 10022
Telephone: 212-736-8600
Facsimile: 212-735-8708
Counsel for Plaintiff

Of Counsel:
Anthony F. Shelley
MILLER & CHEVALIER CHARTERED
655 15th Street, N.W.
Washington, D.C. 20005-5701
Telephone: 202-626-5924
Facsimile: 202-628-0858

[Affidavit of Service omitted for printing.]

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

EMPIRE HEALTHCHOICE ASSURANCE, INC. d/b/a EMPIRE BLUE CROSS BLUE SHIELD,	)	
Plaintiff,	)	
v.	)	Civil Action No. 03-CV-2728 (DC)
DENISE FINN McVEIGH, as Administratrix of the Estate Of JOSEPH E. McVEIGH,	)	
Defendant.	)	

PLAINTIFF'S OPPOSITION TO DEFENDANT'S MOTION TO DISMISS AND FOR SUMMARY JUDGMENT

Plaintiff Empire HealthChoice Assurance, Inc. d/b/a Empire Blue Cross Blue Shield ("Empire") respectfully files this memorandum in opposition to Defendant's motion to dismiss and Defendant's motion for summary judgment.

INTRODUCTION & SUMMARY

This case involves a dispute between Empire and the estate of Joseph E. McVeigh over whether the estate has a duty to reimburse Empire for health benefits Empire paid to or on behalf of Mr. McVeigh. Mr. McVeigh was injured in an accident in 1997, and Empire paid benefits in connection with those injuries. After Mr. McVeigh's death, Defendant Denise Finn McVeigh, the administratrix of Mr. McVeigh's estate, sued in New York State Supreme Court the parties that allegedly caused Mr. McVeigh's injuries. In the same

action, she also sued the alleged tortfeasors in her individual capacity, as did Mr. McVeigh's minor child. On March 19, 2003, Defendant reported to the state court that all parties had agreed to settle all claims in the case for a collective recovery of approximately $3 million. She also reported that Empire claimed a lien on the settlement based on the benefits it had earlier paid; that the estate and Empire had reached an impasse over Empire's entitlement to those funds; that $100,000 had been escrowed to cover part of that lien; and that Empire and the estate had stipulated that Empire would file a claim within 30 days of the hearing to resolve the lien dispute. Additionally, because the settlement involved a minor, Defendant stated that the New York State Surrogate's Court had to approve the terms of the settlement. Defendant maintains that the Surrogate's Court has not yet approved the settlement.

Consistent with the stipulation of the parties, Empire filed this lawsuit against Defendant, as administratrix of the estate, seeking declaratory and other relief to resolve the lien controversy. The complaint raises two counts: one for breach of the terms of the health benefits plan and one for a declaratory judgment that Empire has a lien or subrogation rights. Defendant now moves to dismiss the complaint, raising essentially four arguments: (1) that the Court lacks federal question jurisdiction; (2) that the Court should dismiss the case because it involves an estate subject to probate in the state courts; (3) that the Court should abstain from exercising jurisdiction; and (4) that the case is premature. The estate also moves for summary judgment, contending that the case is barred by a state-law statute of limitations, notwithstanding that Defendant otherwise asserts that this suit is, at the same time, premature.

The Court should deny the motion to dismiss. First, the Court has federal question jurisdiction. Mr. McVeigh was enrolled in one of the federal government's health benefits plans for federal employees, and it is that health benefits plan that Empire here asserts was breached. The

plan is established through federal government contract pursuant to the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. § 8901-8914; moreover, cases involving the plan's interpretation are controlled by federal common law, most notably because it is the federal government's own money that is at risk in such actions. Under the precedents of this and other Circuits, federal courts have jurisdiction over suits seeking the construction of a federal instrument or otherwise turning on federal common law. Second, this suit is not barred by the state courts' jurisdiction over the administration of the estate. The Second Circuit has disparaged the "probate exception" to federal jurisdiction. At a minimum, it has held that federal courts have jurisdiction to declare the rights of parties to assets in an estate, even if those assets might subsequently be distributed in state court proceedings. Third, the Court should not abstain, because none of the relevant abstention doctrines apply. Where federal law governs a case, as it does in this case, federal courts are to exercise their jurisdiction regardless of whether the same federal question could be raised in a state court proceeding. Fourth, the case is not premature. The estate argues that a suit to determine the validity of the lien is not ripe because the Surrogate's Court still must approve the minor's portion of the settlement. But the Second Circuit has repeatedly held that a declaratory judgment claim can present an actual case or controversy even where it is based on contingent rights. Here, the dispute over the lien is concrete and its resolution will even assist the Surrogate's Court in ruling on the appropriateness of the minor's share.

Nor should the Court award Defendant summary judgment based on the statute of limitations. FEHBA preempts the state law statute of limitations that Defendant seeks to apply. Further, the dispute over the lien crystallized only when it became apparent that Defendant had reached a settlement with the alleged tortfeasors, but that she would not honor the lien Empire asserts. In fact, the parties agreed

that Empire would file its suit within 30 days of the recitation in the New York State Supreme Court of the terms of the settlement, and Empire met that deadline. Empire has not missed any relevant deadline, and no conceivable statute of limitations could have passed.

BACKGROUND

A. Contractual and Regulatory Background

FEHBA charges the United States Office of Personnel Management ("OPM") with establishing and regulating health benefits plans for federal employees and their dependents. 5 U.S.C. § 8902(a). Pursuant to this statutory mandate, OPM has entered a federal government contract with the Blue Cross and Blue Shield Association ("BCBSA") to establish the Service Benefit Plan (or "the Plan"), a nationwide fee-for-service plan. *See* 5 U.S.C. § 8903(1); 1997 Statement of Benefits for the Service Benefit Plan at 2 (Exh. C to Compl.) [hereinafter "1997 Statement of Benefits"]; *see generally* 1996 contract between OPM and BCBSA and subsequent amendments (Exh. A to Compl.); 2002 contract between OPM and BCBSA and subsequent amendments (Exh. B to Compl.). In signing the contract, BCBSA acts on behalf of local Blue Cross and Blue Shield companies, which administer the Service Benefit Plan in their respective localities. 1997 Statement of Benefits at 2. Empire is a Blue Cross and Blue Shield company that administers the Plan in New York.

FEHBA also directs OPM to procure such health benefits as the agency "considers necessary or desirable." 5 U.S.C. § 8902(d). In conjunction with this authority, OPM issues to all enrollees in each FEHBA plan a "Statement of Benefits." *See id.* § 8902(d). The Statement of Benefits sets forth the "benefits, including maximums, limitations, and exclusions"; the "procedure for obtaining benefits"; and the "principal provisions of the plan affecting the enrollee and any eligible family members." *Id.* § 8907(b). The Statement of Benefits for the Service Benefit Plan is incorporated into

the OPM-BCBSA contract and is the official description of benefits and other Plan terms. *See* 1997 Statement of Benefits at 2; 1996 contract between OPM and BCBSA, § 2.2(a); 2002 Contract between OPM and BCBSA, § 2.2(a).

One provision in the Statement of Benefits concerns subrogation and reimbursement. Under the Service Benefit Plan, when an enrollee receives benefits in connection with an injury and also receives compensation from the third party who caused the injury, the enrollee must reimburse the local Blue Cross and Blue Shield entity administering the Plan the amount of benefits paid. The subrogation and reimbursement provision states:

> This subrogation and right of recovery provision applies when you or your dependent are sick or injured as a result of the act or omission of another person or party. The Plan has the right to recover payments the Plan has made to you or your dependent from a third party or third party's insurer because of illness or injury caused by a third party. In addition to its right of recovery, the Plan is subrogated to you and your dependent's present and future claims against a third party. Third party means another person or organization.
>
> If you or your covered dependent suffer an injury or illness through the act or omission of another, you and your dependent agree: 1) to reimburse the Plan for benefits paid by the Plan in an amount not to exceed the amount of the recovery; and 2) that the Plan be subrogated to your (or your dependent's) rights to the extent of the benefits paid, including the right to bring suit. All recoveries from a third party (whether by lawsuit, settlement, or otherwise) must be

used to reimburse the Plan for benefits paid. The Plan's share of the recovery will not be reduced because you or your dependent do not receive the full amount of damages claimed, unless the Plan agrees in writing to a reduction.

When you or your dependent make a claim against a third party or the third party's insurer as a result of an injury or illness for which that third party is legally responsible, the Plan shall have a lien on the proceeds of that claim in order to reimburse itself to the full amount of benefits it is called upon to pay. The Plan's lien will apply to any and all recoveries for such claim whether by court order or out-of-court settlement.

If you or your dependent are injured because of a third party's action or omission: 1) the Plan will pay benefits for that injury subject to the conditions that you and your dependent a) do not take any action that would prejudice the Plan's ability to recover benefits, and b) will cooperate in doing what is reasonably necessary to assist the Plan in any recovery; 2) the Plan's right of reimbursement extends only to the amount of Plan benefits paid or to be paid because of the injury; and 3) the Plan may insist upon an assignment of the proceeds of the claim or right of action against the third party and may withhold payment of benefits otherwise due until the assignment is provided.

You are required to notify the Plan promptly of any third party claim that you may have for damages for which the Plan has paid or may pay benefits. In addition, you are required to

> notify the Plan of any recovery, whether in or out of court, that you or your dependent obtain and to reimburse the Plan to the extent of benefits paid by the Plan. Any reduction of the Plan's claim for payment of attorney's fees or costs associated with the claim is subject to prior approval by the Plan.

1997 Statement of Benefits at 12.[1]

Any money recovered through subrogation or reimbursement ultimately inures to the benefit of the United States. This is because the health benefits provided to enrollees under the Service Benefit Plan (as with all FEHBA plans) are subsidized by the United States. The government pays the majority of the premium, with the enrollee paying the remainder. 5 U.S.C. § 8906. These premium funds are then placed in a U.S. Treasury account and disbursed periodically to the local Blue Cross and Blue Shield companies to cover the costs of benefits payments. 5 U.S.C. § 8909(a); 48 C.F.R. § 1632.170(b); Declaration of Clinton Shatzer ¶¶ 4-6 (Exh. A to Declaration of Kieran Bastible, accompanying this Mem.) [hereinafter "Shatzer Decl."]. When a carrier recovers benefits through subrogation and reimbursement, it returns the funds to the Treasury. *See* Shatzer Decl. ¶ 7. Because the United States's own funds are at issue, the government -- in its contract with BCBSA --

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[1] Throughout this brief, we refer to the 1997 Statement of Benefits, since Empire first paid benefits in association with Mr. McVeigh's injuries during that year. Subsequent Statement of Benefits are similar concerning the provisions relevant to this case, including the reimbursement requirement. *See, e.g.*, 1998 Statement of Benefits for the Service Benefit Plan at 12 (Exh. D to Compl.); 1999 Statement of Benefits for the Service Benefit Plan at 12 (Ex. E. to Compl.); 2000 Statement of Benefits for the Service Plan at 12 (Exh. F to Compl.); 2001 Statement of Benefits for the Service Benefit Plan at 86 (Exh. G to Compl.).

has specified that BCBSA and the local Blue Cross and Blue Shield companies shall make a "reasonable effort to seek recovery of amounts [they are] entitled to recover in cases which are brought to [their] attention." 1998 amendment to contract between OPM and BCBSA § 4.1(e) (altering § 2.5) (Exh. A to Compl.); *see also* 2002 contract between OPM and BCBSA § 4.1(h) (altering § 2.5).

Finally, FEHBA contains an express preemption provision. It states: "The terms of any contract under this chapter which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans." 5 U.S.C. § 8902(m)(1) (2000). "The policy underlying section 8902(m)(1) is to ensure uniformity in the administration of FEHBA benefits." *Hayes v. Prudential Ins. Co. of Am.*, 819 F.2d 921, 925 (9th Cir. 1987); *see* H.R. Rep. No. 105-374, at 9, 16 (1997) (provision "strengthen[s] the ability of national plans to offer uniform benefits and rates to enrollees regardless of where they may live") (Exh. B to Declaration of Kieran Bastible, accompanying this Mem.); *see also* 1996 contract between OPM and BCBSA § 4.1(d) (adding § 2.5(f)) (providing that subrogation shall be done "a single, nation-wide policy" to ensure "consistent treatment").

B. Benefits Claims and Proceedings Involving Mr. McVeigh

At the times relevant to this case, Joseph E. McVeigh was enrolled in the Service Benefit Plan. Compl. ¶ 7. In 1997, Mr. McVeigh suffered injuries in an accident. Compl. ¶ 8; *see also* Answer (nowhere denying ¶ 8 of the Complaint). Between 1997 and 2001, Empire paid benefits under the Service Benefit Plan for medical treatment relating to Mr. McVeigh's injuries. Compl. ¶ 10. Mr. McVeigh died in November 2001. Compl. ¶ 11; Answer (nowhere denying ¶ 11 of the Complaint). Defendant is the administratrix of Mr. McVeigh's estate. Def.'s Stmt. of Undisputed Facts ¶ 2

(Exh. 2 to Def.'s Affirmation in Supp. of Mot. to Dismiss and for Summ. J.). Defendant alleges that the administration of the estate remains ongoing in the Surrogate's Court for New York County. *See id.* ¶ 4.

On behalf of the estate and on her own behalf, Defendant has sued the third parties that allegedly caused Mr. McVeigh's injuries in New York State Supreme Court; Mr. McVeigh's minor child also joined in that suit. *See* Compl. ¶ 12; Tr. of Testimony in *Finn v. Town of Southampton*, Index No. 11335/98 (Mar. 19, 2003) (Exh. C to Declaration of Kieran Bastible, accompanying this Mem.) ("As everyone knows, there are four causes of action involved in this case: a claim for personal injury by Denise Finn, a claim for loss of consortium by Denise Finn, a claim on behalf of the Estate of Joseph McVeigh for pain and suffering, and a wrongful death claim on behalf of his distributees.") [hereinafter "State Court Tr."]. At a hearing in that case on March 19, 2003, counsel for Defendant reported that the parties to the state court action had agreed to settle the estate's claims, Ms. McVeigh's individual claims, and the minor's claims for a total of $3,175,000 million. State Court Tr. at 7 ("It is hereby stipulated and agreed by counsel for the plaintiff and the defendants . . . that the action is settled for the total sum of 3,175,000.").

Prior to the hearing, Empire had notified Defendant's counsel by letter that it had a lien against the estate's portion of the tort settlement in the amount of $157,309.06. *See* Compl. ¶ 14; Letter from Howard F. Wolfson to Thomas J. Stock at 2 (Mar. 11, 2003) (Exh. H to Compl.). In response to that letter, counsel for Defendant disputed the existence of a lien. *See* Letter from Thomas J. Stock to Howard S. Wolfson (Mar. 13, 2003) (Exh. I to Compl.); *see also* Letter from Thomas J. Stock to Alfredo J. Alvarado at 1 (Mar. 7, 2003) (Exh. J to Compl.) (stating that Empire "never has and never will have a lien on the recovery in [the tort] action"). At the March 19 hearing, counsel for Defendant reiterated that "there is a claim of lien by Empire Blue Cross/Blue

Shield of $175,000 approximately, and we dispute the lien." State Court Tr. at 9-10.

Because of the dispute over the lien, counsel for Defendant indicated to the state court at the March 19 hearing that he had "agreed with counsel for the alleged lien holder [*i.e.*, Empire] to hold in escrow the sum of $100,000 until there is a resolution of that lien holder's claim." *Id.* at 10. Defendant and Empire further agreed "that the extent of the lien holder's lien, if any, is still in issue, and that [Empire is] not waiving any portion of their claim at this time, they are merely agreeing that they will not bring any claim against anyone else involved in this case to assert their lien other than the estate of Joseph McVeigh." *Id.* Defendant and Empire also agreed that Empire would "bring any claim that they intend to bring within thirty days or be time barred from doing so." *Id.*

Consistent with its representation to the state court, Empire brought this action for reimbursement within 30 days of the March 19 hearing, on April 18, 2003. Its complaint raises two claims: one for breach of contract and one for declaratory judgment. The contract claim asserts that, "[u]nder the provisions of the Service Benefit Plan, Defendant -- on the estate's behalf -- is obligated to reimburse Empire for the full amount of benefits the Decedent received, upon the estate's recovery from the third parties associated with Decedent's injuries." Compl. ¶ 19. Because "Defendant has flatly rejected Empire's assertion of a lien," she has "breached and imminently will further breach obligations under the Service Benefit Plan." *Id.* Similarly, the Declaratory Judgment claim avers that Defendant has refused Empire's demand for reimbursement and that "an actual and justiciable controversy has arisen between Empire and Defendant" as to Empire's "right to reimbursement of the amount of benefits paid by Empire on behalf of the Decedent for treatment of the Decedent's injuries, pursuant to the express terms of the Service Benefit Plan." *Id.* ¶ 23. In this claim, Empire alleges that it "is

entitled to a judgment declaring that, pursuant to the express terms of the Service Benefit Plan, as well as FEHBA, its implementing federal regulations, and federal common law, it has the right to reimbursement from Defendant for the amount of benefits paid by Empire on behalf of the Decedent for treatment of the Decedent's injuries." *Id.* ¶ 24.

In its prayer for relief, Empire requests that the Court "declare that Empire has a lien in the amount of $157,309.06 against the settlement proceeds of Defendant Denise Finn McVeigh relating to her state court claim on behalf of Decedent's estate against the third parties alleged to have caused Decedent's injuries." *Id.* at page 8. Empire also requests judgment against the Defendant in the same amount, an order requiring disbursement of the $100,000 escrow account to Empire, and an order directing Defendant to pay the additional amount of $57,309.06 upon receipt of settlement funds in connection with her tort suit on the estate's behalf. *Id.*

ARGUMENT

I. THE COURT SHOULD DENY DEFENDANT'S MOTION TO DISMISS

A. The Court Has Federal Question Jurisdiction

Defendant's principal argument in support of dismissal is that the Court lacks jurisdiction under 28 U.S.C. § 1331 because the case allegedly does not "require the resolution of a substantial Federal question." Def.'s Affirmation ¶ 5. But the Supreme Court has consistently held that a complaint raises a federal question where any one of its claims "necessarily turn[s] on some construction of federal law." *Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 463 U.S. 1, 9 (1983); *accord City of Chicago v. Int'l College of Surgeons*, 522 U.S. 156, 164 (1997) (even state law claim raises a federal question where it "turn[s] exclusively on federal law"); *see also id.* (a "federal question exists when a 'right or immunity created by the Constitution or laws of the United States [is] an element, and an essential

one, of the plaintiff's cause of action'") (quoting *Gully v. First Nat'l Bank in Meridian*, 299 U.S. 109, 112 (1936)). Here, Empire's claims turn on both the interpretation of a federal government contract, which is federal law, and of federal common law.

1. Empire's Claims Turn on a Federal Government Contract, Which Is Federal Law

That a claim turning on a federal government contract or other federal instrument raises a federal question is illustrated by the Second Circuit's decision in *Marcus v. AT&T Corp.*, 138 F.3d 46 (2d Cir. 1998). There, a consumer brought a "breach of warranty" claim against AT&T, alleging failure to comply with the company's published rates and policies. *Id.* at 55. When the consumer later appealed AT&T's removal of the case to federal court, "AT&T argue[d] that the breach of warranty claim necessarily arises from AT&T's only contract between it and its consumers -- the tariff filed with the FCC in accordance with 47 U.S.C. § 203(a)." *Id.* at 55-56. "Because the tariff is filed with the FCC pursuant to [the Federal Communications Act ("FCA")], AT&T argue[d] the breach of warranty claim arises under federal law." *Id.* at 56. The Second Circuit "agree[d]." *Id.* It found that the source of the rate agreements that appellants sought to enforce was "the tariffs filed in accordance with the FCA." *Id.* These tariffs were not "mere contracts" between private parties; they were "federal law," since they were documents maintained with the FCC that "conclusively and exclusively enumerate the rights and liabilities of the contracting parties." *Id.* (internal quotation marks omitted). Because the tariffs were federal law, and the breach-of-warranty claim hinged on them, the claim "necessarily raise[d] a substantial federal question over which federal courts may properly exercise jurisdiction." *Id.*

Like the claims in *Marcus*, Empire's claims seek enforcement of a federal contractual arrangement that constitutes federal law, thereby raising federal questions.

Each of Empire's claims turns on the reimbursement terms in the Service Benefit Plan's Statement of Benefits. As with the tariffs in Marcus, the Statement of Benefits is not a mere contract between private parties; rather, it has the full force and effect of federal law. To start with, the Statement of Benefits is part of a government contract, with a federal agency -- OPM -- being a party to that contract. Indeed, the Statement of Benefits itself is an promulgation of the agency. Under FEHBA, it is OPM that has responsibility for publishing "an appropriate document" setting forth the benefits "to which the enrollee . . . [is] entitled." 5 U.S.C. § 8907(b). Because the Statement of Benefits is an OPM promulgation, its "provisions are rules under the Administrative Procedure Act, 5 U.S.C. § 551(4)." *Caudill v. Blue Cross & Blue Shield of N.C., Inc.*, 999 F.2d 74, 80 (4th Cir. 1993). As part of a federal government contract and as an agency rule, the Statement of Benefits is federal law.

FEHBA's express preemption provision further establishes that the Statement of Benefits is federal law. This section provides that the Statement of Benefits has the same legal effect as federal statutes and regulations by stating that "the terms of any [FEHBA] *contract* . . . which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits)" shall supersede state laws relating to health insurance and plans. 5 U.S.C. § 8902(m)(1) (emphasis added). The Statement of Benefits could not readily supersede state law if it were not federal law.

Because Empire's claims involve construction and enforcement of the Statement of Benefits's reimbursement terms, and because the Statement of Benefits is federal law, Empire's complaint "raises a substantial federal question." *Marcus*, 138 F.3d at 56. On this basis, the Court has jurisdiction. *See generally Price v. Pierce*, 823 F.2d 1114, 1120 (7th Cir. 1987) (breach-of-contract claim falls within federal courts' jurisdiction where it seeks enforcement of

federal housing agreement); *Eatmon v. Bristol Steel & Iron Works, Inc.*, 769 F.2d 1503, 1514-17 (11th Cir. 1985) (breach-of-contract claim "arose under" federal law because relevant contract was "conciliation agreement" entered with federal government); *accord Guardian Nat'l Acceptance Corp. v. Swartzlander Motors, Inc.*, 962 F. Supp. 1137, 1143 (N.D. Ind. 1997); *Amoco Chem. Co. v. Tex Tin Corp.*, 902 F. Supp. 730, 735 (S.D. Tex. 1995).

2. Empire's Claims Turn on Federal Common Law

Alternatively, Empire's complaint falls within the Court's federal question jurisdiction because it turns on the construction of federal common law. "It is beyond dispute that if federal common law governs a case, that case presents a federal question within the subject matter jurisdiction of the federal courts, just as if the case were governed by a federal statute." *Woodward Governor Co. v. Curtiss-Wright Flight Sys., Inc.*, 164 F.3d 123, 126 (2d Cir. 1999). As articulated by the Supreme Court in *Boyle v. United Technologies Corp.*, 487 U.S. 500 (1988), there is a two-part test for determining whether a claim is controlled by federal common law. First, "as a threshold matter, a case must implicate 'uniquely federal interests' for federal common law to apply." *Woodward Governor Co.*, 164 F.3d at 127 (quoting *Boyle*, 487 U.S. at 504). Second, there must be a "'significant conflict between some federal policy or interest and the use of state law.'" *Id.* (quoting *O'Melveny & Myers v. FDIC*, 512 U.S. 79, 87 (1994), and citing Boyle, 487 U.S. at 504). Empire's claims, which, again, seek construction and enforcement of the reimbursement provisions of the Service Benefits Plan's Statement of Benefits, satisfy both parts of the test.

Reimbursement under the FEHBA program is an area of uniquely federal concern because it involves the United States's own money. The government subsidizes the health benefits it supplies to its employees, and its contributions are

placed in a special account in the U.S. Treasury from which benefits are paid. *See supra* p. 6. The money that carriers collect in reimbursement when benefits are paid back is, in turn, returned to the U.S. Treasury. *See id.*; Shatzer Decl. ¶ 7. The Second Circuit in *Woodward Governor Co.* recognized that "the obligations to, and rights of, the United States under its contracts" involve uniquely federal interests, and here what is at issue is the right of the United States ultimately to obtain funds in reimbursement pursuant to the terms of its contract for the Service Benefit Plan. The uniquely federal character of this suit is not altered merely because it is a FEHBA carrier, rather than the United States directly, who seeks to collect the money for the government (pursuant to the reimbursement provisions of the FEHBA contract). The rights and "liabilit[ies] of independent contractors performing work for the Federal Government, like the liability of federal officials [themselves], is an area of uniquely federal interest." *Boyle*, 487 U.S. at 505 n.1 (emphasis added); *see Woodward Governor Co.*, 164 F.3d at 128 (noting that suit between private parties can implicate uniquely federal interests if "the United States is exposed to some potential loss").

Not only are uniquely federal interests present in this case, but there is also a significant conflict between those federal interests and the application of state law. A chief Congressional goal undergirding FEHBA is "uniformity in the administration of FEHBA benefits." *Hayes v. Prudential Ins. Co. of Am., Inc.*, 819 F.2d 921, 925 (9th Cir. 1987); *accord Burkey v. Gov't Employees Hosp. Ass'n*, 983 F.2d 656, 660 (5th Cir. 1993). FEHBA's preemption provision overtly seeks to further this objective. *See Caudill*, 999 F.2d at 79. The goal of uniformity finds further articulation in the reimbursement provisions of the contract between OPM and BCBSA for the Service Benefit Plan, which provide that local Blue Cross and Blue Shield companies shall seek reimbursement "under a single, nation-wide policy to ensure equitable and consistent treatment for all Members under this

contract." 1996 contract between OPM and BCBSA § 4.1(d) (adding § 2.5(f)) (Exh. A to Compl.); 1997 amendment to contract between OPM and BCBSA § 4.1(d) (amendment 10) (Exh. A to Compl.); *see also* 2002 contract between OPM and BCBSA § 2.3(g) (Exh. C to Compl.).

The application of state law would "subvert this policy [of uniformity]." *Rievley v. Blue Cross/Blue Shield of Tenn.*, 69 F. Supp. 2d 1028, 1037 (E.D. Tenn. 1999). For instance, if state law were to apply in reimbursement matters, then enrollees in states with strong policies against subrogation could avoid reimbursement when they obtain a recovery from a third party, whereas enrollees in other states that more readily allow subrogation would have to repay. That would be inequitable, given that all enrollees contribute the same amount toward premiums (*see* 5 U.S.C. § 8906), but enrollees in some states would enjoy an advantage -- namely, the avoidance of reimbursement -- that enrollees in other states would not. *See* Caudill, 999 F.2d at 79 (emphasizing that application of state law in FEHBA benefits suits would be "fundamentally unfair to many federal employees covered by Blue Cross contracts because enrollees in some states would pay higher premiums to cover benefits provided only in other states"). "As an employer, the federal government has an overwhelming interest in ensuring that all of its employees subject to a particular health insurance policy are treated equally regardless of the state in which they live, and the application of state law interferes with this interest." *Id.* at 79.

Both of *Boyle*'s requirements for the application of federal common law, then, are here satisfied, and Empire's claims accordingly are governed by federal common law and subject to federal jurisdiction. The Eighth Circuit reached a similar conclusion in *MedCenters Health Care v. Ochs*, 26 F.3d 865, 867 (8th Cir. 1994), where it held that a FEHBA carrier's claim for reimbursement from an enrollee was subject to federal jurisdiction because "FEHBA pre-empt[s] the state-law rule in this instance." *See also MedCenters*

Health Care v. Ochs, 854 F. Supp. 589, 591-92 (D. Minn. 1993) (in rejecting enrollee's challenge to federal jurisdiction, and then requiring reimbursement, district court held that "federal law controls interpretation of [FEHBA] contractual provision and the resulting rights and obligations of the parties"), *aff'd*, 26 F.3d 865 (8th Cir. 1994). The application of federal common law to -- and thus federal jurisdiction over -- Empire's claims is further bolstered by the myriad decisions from this and other courts finding that the interpretation of FEHBA plan provisions (provisions on which Empire's complaint relies) is governed exclusively by federal law. *E.g., Fed. Plaza Med. Assocs., P.C. v. Palermino*, No. 87 Civ. 6777 (MGC), 1991 U.S. Dist. LEXIS 2167, at *15 (S D.N.Y. Feb. 22, 1991) ("Because the brochure [*i.e.*, the Statement of Benefits] is part of a federal procurement contract, its interpretation is governed by federal law."); *Harris v. Mut. of Omaha Corp.*, 992 F.2d 706, 711 (7th Cir. 1993) (same); *Tackitt v. Prudential Ins. Co.*, 758 F.2d 1572, 1575 (11th Cir. 1985) (same).

B. The Probate Exception to Federal Jurisdiction Is Inapplicable in This Instance

Defendant's next argument is that the Court has no jurisdiction because the estate is currently the subject of administration by the New York State Surrogate's Court. *See* Def.'s Affirmation ¶ 20 (relying on *Beach v. Rome Trust Co.*, 269 F.2d 367 (2d Cir. 1959)). Though she does not put it in so many words, Defendant here invokes what has been called the "the probate exception to federal diversity jurisdiction." *Moser v. Pollin*, 294 F.3d 335, 340 (2d Cir. 2002) (emphasis added). Under this exception, "a federal court may not probate a will, administer an estate, or entertain an action that would interfere with pending probate proceedings in a state court or with a state court's control of property in its custody." *Ashton v. Josephine Bay Paul & C.*

Michael Paul Found., Inc., 918 F.2d 1065, 1071 (2d Cir. 1990).

The probate exception is disfavored in the Second Circuit. The Court of Appeals has described it as "'one of the most mysterious and esoteric branches of the law of federal jurisdiction.'" *Id.* at 1071 (quoting *Dragan v. Miller*, 679 F.2d 712, 713 (7th Cir. 1982)). It has characterized the doctrine's rationale -- rooted as it is in the distinction between the "courts of chancery" and the "ecclesiastical courts in England" -- as "dubious." *Id.* (internal quotation marks omitted).

Whatever its general merits, the probate exception has no application in this case. As its title indicates, the exception is to diversity jurisdiction. This case, as we have shown, involves a federal question. The exception does not apply in federal question cases. *See In re Goerg*, 844 F.2d 1562, 1565 (11th Cir. 1988); *Powell v. Am. Bank & Trust Co.*, 640 F. Supp. 1568, 1575 (N.D. Ind. 1986); 15 James Wm. Moore et al., *Moore's Fed. Practice* ¶ 102.92[1] (3d ed. 1999); *cf. Ashton*, 918 F.2d at 1072 (declining to apply probate exception even in diversity context, where case was brought under federal interpleader statute available to diverse parties).

Furthermore, Empire's claims fall outside of the probate exception because its claims for a lien on the settlement proceeds would not, if forced into the state courts, be exclusively cognizable in the Surrogate's Court. As Defendant indicated at the hearing, the State Supreme Court could hear Empire's claim to the lien. State Court. Tr. at 10 (counsel for estate noting at Supreme Court hearing that he might seek "to have this court resolve [the lien] issue" through an "order to show cause") (emphasis added). "The standard for determining whether federal jurisdiction may be exercised is whether under state law the dispute would be cognizable only by the probate court," rather than "in a state court of general jurisdiction." *Lamberg v. Callahan*, 455 F.2d 1213, 1216 (2d Cir. 1972).

Perhaps most important, even assuming that the probate exception has relevance in federal question cases and that the Surrogate's Court has exclusive jurisdiction among the state courts to determine the lien, the doctrine never reaches claims seeking to declare rights to the assets of an estate, as opposed to the actual distribution of the estate's assets or an accounting. "From the earliest probate cases in the federal courts a definite if not always precise line has been drawn between claims seeking to contest management or to effect a distribution of property, and those merely seeking a judgment in personam declaring the plaintiff entitled to receive from the fiduciary an interest in the estate." *Beach*, 269 F.2d at 372. "Merely determining the rights to, as opposed to administering assets, is not proscribed by the probate exception." *Ashton*, 918 F.2d at 1072; *accord Markham v. Allen*, 326 U.S. 490, 494 (1946) ("[W]hile a federal court may not exercise its jurisdiction to disturb or affect the possession of property in the custody of a state court, it may exercise its jurisdiction to adjudicate rights in such property where the final judgment does not undertake to interfere with the state court's possession save to the extent that the state court is bound by the judgment to recognize the right adjudicated by the federal court.").

The first form of relief that Empire seeks in its complaint is a declaration that it has a lien on the estate's settlement proceeds for health benefits it has paid (*see* Compl., Prayer for Relief, ¶ A), and one of Empire's claims is for a declaratory judgment. *See id.* ¶¶ 20-24. Through a declaratory judgment, the Court would simply be adjudicating "a controversy concerning the right of the plaintiff to share in the res"; it would not "undertake the general administration of the [estate's] property." *Beach*, 269 F.2d at 372. None of the precedents involving the probate exception preclude this declaration of rights. It is true that the complaint's prayer for relief additionally seeks distribution of the escrow fund and additional moneys from the settlement proceeds. But each form of relief requested is

to be evaluated on its own merits for purposes of the exception, *see In re Thomas & Agnes Carvel Found.*, 36 F. Supp. 2d 144, 149 (S.D.N.Y. 1999), and Empire unquestionably seeks, as one form of relief, a declaration of rights that the cases uniformly hold to be outside of the exception. In any event, even the forms of relief other than declaratory relief that Empire seeks are not barred by the probate exception because, as noted, this is a federal question case.[2]

C. The Court Should Not Abstain from Exercising Its Jurisdiction

Defendant contends that, "[e]ven assuming that this Court is not required to dismiss the within claims, this Court clearly has the power to decline to assert jurisdiction under the circumstances presented." Def.'s Affirmation ¶ 21. This is an abstention argument, although again not identified in so many words. There are two abstention doctrines that Defendant here might be contemplating -- the one described in *Wilton v. Seven Falls Co.*, 515 U.S. 277, 289-90 (1995), and the one detailed in *Colorado River Water Conservation Dist. v. United States*, 424 U.S. 800, 818 (1976).

Wilton applies in situations where a litigant seeks declaratory relief. It permits a federal court to decline jurisdiction "in the sound exercise of its discretion" if there are "parallel state proceedings" and if "considerations of

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[2] With respect to Empire's request for distribution to it of its share of the settlement proceeds, it is also worth emphasizing that the probate exception, where it otherwise applies (and, again, that is in diversity cases), only limits the distribution of "property in the custody of a state court." *Markham*, 326 U.S. at 494. The majority of the money that Empire seeks will never become the estate's assets and thus be subject to the Surrogate Court's jurisdiction, since it is specifically being held in an escrow account to avoid its transfer to the estate.

practicality and wise judicial administration" so indicate. *Wilton*, 515 U.S. at 288, 289. *Colorado River* applies where relief other than declaratory relief is sought. It is less permissive than *Wilton*, for it is "'an extraordinary and narrow exception to the duty of a District Court to adjudicate a controversy properly before it.'" *Burnett v. Physician's Online, Inc.*, 99 F.3d 72, 77 (2d Cir. 1996) (quoting *Colorado River*, 424 U.S. at 813). As with *Wilton*, abstention under Colorado River requires parallel proceedings in a state court and "'rests on considerations of wise judicial administration, giving regard to conservation of judicial resources and comprehensive disposition of litigation.'" *Id.* at 76 (quoting Colorado River, 424 U.S. at 817). In all instances, the *Colorado River* inquiry is "'heavily weighted in favor of the exercise of [federal] jurisdiction.'" *Id.* (quoting *Moses H. Cone Mem. Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 16 (1983)). The Second Circuit has held that, where -- as is the case with Empire's complaint -- the plaintiff seeks both declaratory and other relief (such as an injunction or damages), *Colorado River* is the governing doctrine, not *Wilton*. *Village of Westfield, N.Y. v. Welch's*, 170 F.3d 116, 124 n.5 (2d Cir. 1999).

Nonetheless, whether it is *Wilton* or *Colorado River* that is implicated, none of the factors guiding the exercise of these abstention doctrines is present in this case. Foremost, these abstention doctrines are more appropriately applied where state law, not federal law, governs the case's substantive legal issues. For example, *Wilton* involved a declaratory judgment action where state law governed. The Supreme Court specifically declined to determine whether the same abstention principles would pertain to "cases raising issues of federal law." *Wilton*, 515 U.S. at 290. Since *Wilton*, the Second Circuit has rejected abstention under *Wilton* if the declaratory action involves "questions of federal law." *Youell v. Exxon Corp.*, 74 F.3d 373, 376 (2d Cir. 1996). Likewise, under *Colorado River*, "the presence of federal issues strongly advises exercising federal

jurisdiction." *City of Westfield, N.Y.*, 170 F.3d at 124. Because Empire's claims are governed by federal law, the Court should reject abstention on that basis.

The relevant factors also do not favor abstention because, under both *Wilton* and *Colorado River*, there must be parallel state court proceedings to which the federal court can defer. For state and federal proceedings to be parallel, they must be "essentially the same; that is, there is an identity of parties, and the issues and relief sought are the same." *Nat'l Union Fire Ins. Co. v. Karp*, 108 F.3d 17, 22 (2d Cir. 1997). Here, Defendant refers to an "administration proceeding now pending" in the Surrogate's Court as the parallel state court matter. Def.'s Affirmation ¶ 22. But the Surrogate's Court proceeding (which McVeigh fails to identify with any specificity) cannot share an identity of parties or issues with this case. Empire is not a party to the "administration proceeding" or to any other pending state court action involving Defendant. It has not received or filed any pleadings in any Surrogate's Court action involving its disputed lien or subrogation rights. Moreover, the probate of an estate does not involve the same legal issues as a creditor's suit seeking relief from the decedent. Without parallel state court proceedings, abstention cannot apply.

Abstention also would not avoid "piecemeal litigation" or otherwise conserve judicial resources. *Burnett*, 99 F.3d at 76. If the determination of Empire's lien were left to the state courts, the appropriate forum for resolution of the lien -- as Defendant has already admitted -- would be the State Supreme Court. *See* State Court. Tr. at 10. Hence, if this Court relinquished jurisdiction, there would still be two ongoing proceedings -- one in the Supreme Court and one in the Surrogate's Court. Dismissing or staying the federal suit in favor of an additional state court suit would not promote judicial economy. Furthermore, if Defendant were to raise the issue of Empire's lien in state court (such as through the "show cause" order she threatened in the State Supreme Court, *see id.*), Empire could rightfully remove that case to

this Court. No matter how Defendant might artfully plead the issue, the determination of the lien turns on the construction of the terms of a federal government contract, thereby giving Empire a removal right. *See Marcus v. AT&T Corp.*, 138 F.3d 46, 55-56 (2d Cir. 1998). Accordingly, the practical result of abstention might be that the parties return here, albeit after having had to introduce the lien claim in state court and then remove the case to this Court.

For all of these reasons, the Court should decline Defendant's invitation to abstain from exercising its jurisdiction. The federal courts have "a 'virtually unflagging obligation' to exercise their jurisdiction," *Burnett*, 99 F.3d at 76 (quoting *Colorado River*, 424 U.S. at 817), and the circumstances of this case do not discharge the Court of that obligation.

D. This Action Is Not Premature

Defendant's last dismissal argument is that "it is premature and improper" to hear this case because the "Surrogate's Court has not yet approved any settlement." Def.'s Affirmation ¶ 27. Thus, Defendant maintains that "[i]t is unknown if any settlement proceeds will be paid to the Estate" from which Empire could collect its lien. *Id.* In Defendant's view, the Court cannot "grant a lien against something that does not yet exist and may never exist, against a person or entity as yet unknown." *Id.*

Contrary to Defendant's assertion, the Court can -- at a minimum -- issue a declaratory judgment determining Empire's right to reimbursement, regardless of whether any settlement has yet been approved. The Declaratory Judgment Act allows a court to declare rights of litigants in an "actual controversy" within the federal courts' jurisdiction. 28 U.S.C. § 2201(a). As with any claim, federal courts may not resolve purely academic or abstract legal questions in the context of a declaratory suit. *See, e.g., Aetna Life Ins. Co. v. Haworth*, 300 U.S. 227, 239-40 (1937). However, "[t]hat the liability may be contingent does not

necessarily defeat jurisdiction of a declaratory judgment action." *Assoc. Indemn. Corp. v. Fairchild Indus., Inc.*, 961 F.2d 32, 35 (2d Cir. 1992). "Where there is an actual controversy over contingent rights, a declaratory judgment may nevertheless be granted." *Am. Mach. & Metals, Inc. v. De Bothezat Impeller Co.*, 166 F.2d 535, 536 (2d Cir. 1948); *accord Lumbermens Mut. Cas. Co. v. Borden Co.*, 241 F. Supp. 683, 690 (S.D.N.Y. 1965); *Nat'l Railroad Passenger Corp. v. Consol. Rail Corp.*, 670 F. Supp. 424, 430 (D.D.C. 1987).

Indeed, "litigation over insurance coverage has become the paradigm for asserting jurisdiction despite 'future contingencies that will determine whether a controversy ever actually becomes real.'" *Assoc. Indemn. Corp.*, 961 F.2d at 35 (quoting 10A C. Wright, A. Miller & M. Kane, *Federal Practice & Procedure* § 2757, at 586 (2d ed. 1983)). The Court of Appeals's decision in *E.R. Squibb & Sons, Inc. v. Lloyd's & Cos.*, 241 F.3d 154 (2d Cir. 2001), nicely illustrates the exercise of jurisdiction in an insurance setting where the claims were based on the occurrence of contingent events. In *E.R. Squibb*, a drug manufacturer faced mounting liability in litigation involving one of its products. The manufacturer, Squibb, had primary insurance policies with a coverage limit of $100 million. *Id.* at 159. Squibb sued several of its excess insurers for a declaration that the excess insurance policies would cover liability over $100 million. *Id.* The excess insurers argued that, because Squibb's liabilities had not yet exceeded that amount, the declaratory judgment action was premature. *Id.* The court disagreed, stating that the only real issue was the "practical likelihood" that the contingency would occur. *Id.* at 177. Because Squibb's liability already approached $100 million, the fact that an additional 900 claims were pending against Squibb convinced the court that the contingency likely would ultimately transpire. *Id.*

In Empire's case, the contingency is more imminent and arguably more certain than in *E.R. Squibb*. Although

Defendant has not yet received any settlement proceeds, she did sue the alleged tortfeasors and has agreed to settle the suit. Empire does not dispute that its right to part of the proposed settlement proceeds is conditional on the settlement becoming final, but the settlement now verges on fruition. Had Empire filed for declaratory judgment *before* Defendant ever filed her lawsuit, its rights might have been more hypothetical than actual. But that is not this case. Instead, all that remains is for the Surrogate's Court to approve the part of the settlement relating to the decedent's minor child. Because the facts indicate that a settlement is potentially at hand, Empire's claim for a declaration of its rights to a share of the settlement proceeds is not premature.

Additionally, resolution of Empire's lien rights would have an immediate and concrete impact on any proceeding by the Surrogate's Court to approve the settlement. The Surrogate, if Defendant's statements are to be believed, must judge the fairness and propriety of the minor's part of the settlement. That task is complicated by the fact that some of the money sits in escrow awaiting resolution of the lien issue, leaving the Surrogate to guess the total amount that might be available for distribution. And the Surrogate cannot fully compare the minor's portion of the settlement to the estate's portion to determine if the minor's share is equitable without knowing what amount of the proceeds the estate will be permitted to keep. Put differently, a settlement that appears to compensate the estate too generously might become more acceptable if it is clear that the estate will have to relinquish some of its recovery to a third party. Thus, this Court's resolution of Empire's claims will clarify an issue that currently clouds the tort settlement.

That, in fact, was the reason Defendant and Empire agreed that Empire would, within 30 days of the announcement of the settlement at the State Supreme Court, file an action to determine its lien. Having resolved that Empire should bring the case within a 30-day deadline so as to clear title to the funds, Defendant now maintains that the

case cannot be brought -- potentially for months -- until the Surrogate approves the settlement. Defendant's position is not only inconsistent with the rule that declaratory relief can be sought where events remain contingent, but is disingenuous, given Defendant's insistence on the 30-day filing deadline.

Empire will concede that its requests for actual distribution of the escrow fund and additional settlement amounts to it (from the estate's portion) might not become ripe until final approval of the settlement. Because Empire is not a party to the Surrogate's Court proceeding, it cannot predict when that approval might occur. However, approval could come at any time. If it happens before this Court rules on Empire's request for declaratory relief, Empire's other requests for relief would be fully cognizable. *See* Fed. R. Civ. P. 54(c) (noting that District Court should award relief appropriate at time of *final* judgment). In the meantime, the Court has authority to declare Empire's right to a lien, regardless of whether the Surrogate has or ever will approve the settlement.

II. THE COURT SHOULD DENY DEFENDANT'S REQUEST FOR SUMMARY JUDGMENT

Defendant does not clearly delineate the bases for her summary judgment motion. Defendant appears to argue that summary judgment is warranted because of a state law statute of limitations and because the Defendant is an estate, not an actual Service Benefit Plan enrollee. Both arguments are meritless.

On the statute of limitations, Defendant contends that section 1810 of the New York State Surrogate's Court Procedure Act applies to this action. Citing correspondence between the parties, Defendant argues that Section 1810 required this action to be brought within 60 days of a 1999 letter in which Defendant supposedly rejected Empire's lien claim. Def.'s Affirmation ¶ 24. As an initial matter, the Court should recognize the inconsistency in this argument

with Defendant's other positions. In one part of her brief, Defendant argues that this action is premature because the Surrogate has not approved the settlement, yet now she asserts that the action is too late. In any event, under FEHBA's express preemption section, FEHBA preempts all state laws that relate to "coverage or benefits (including payments with respect to benefits)." 5 U.S.C. § 8902(m)(1). This includes state statutes of limitations that litigants seek to utilize in benefits matters. *See, e.g., Fuller v. Blue Cross & Blue Shield of Fla., Inc.*, 677 F. Supp. 1131, 1133 (N.D. Fla. 1987).

Even if the state limitations period did apply, its requirement that an action be filed within 60 days of rejection of a claim was not triggered in 1999. The correspondence shows that Defendant did not reject the claim at the time, but sought to begin a dialogue to better understand the legal basis for the claim of lien and vowed to keep Empire abreast of developments in the tort action. *See* Letter from Victor Carr to David Berger (Dec. 17, 1999) (Exh. 5 to Def.'s Affirmation). The state law also only applies where the suing party seeks to collect a debt from the general assets of an estate, not from specifically segregated funds. *Puro v. Puro*, 350 N.Y.S.2d 931, 935-36 (N.Y. Sup. Ct. 1972). Finally, if Empire had filed a court action in 1999, there would have been no "actual controversy" sufficient for a declaratory judgment, since there was no inkling at the time that there would ever be any recovery of any sort.

As to Defendant's claim that reimbursement is available only from a "member" (Def.'s Affirmation ¶ 28), with Defendant's argument presumably being that recovery cannot be made from the estate of a no-longer-living member, there is nothing in the Statement of Benefits (or other FEHBA contractual documents) suggesting that the member's debt should not -- as with all other debts -- redound to his estate upon his death. *See Tulsa Prof. Collection Servs., Inc.*, 485 U.S. 478, 493 (1988) (Rehnquist,

C.J., dissenting) ("probate codes universally require that the estate settle the debts of the decedent"). In FEHBA matters, the courts have not distinguished between members and the estates of members. *See, e.g., Robinson v. Humana Group Health Plan*, 1996 U.S. Dist. LEXIS 16578 (D.D.C. Nov. 4, 1996) (addressing claims for benefits by estate of member).[3]

CONCLUSION

The Court should deny Defendant's motions to dismiss and for summary judgment.

Respectfully submitted,

EMPIRE BLUE CROSS &
BLUE SHIELD

By: /s/

Kieran X. Bastible
MORRISON COHEN
SINGER & WEINSTEIN, LLP
750 Lexington Avenue
New York, NY 10022
Telephone: 212-736-8600
Facsimile: 212-735-8708
Counsel for Plaintiff

[Affidavit of Service omitted for printing.]

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[3] Ultimately, summary disposition will be appropriate in this case -- but in *Empire*'s favor. There can be no reasonable dispute that Empire has a right of reimbursement under the terms of the Statement of Benefits and the amount is readily discernible. Empire will shortly, by separate motion, move for summary judgment on its claims.

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

EMPIRE HEALTHCHOICE ASSURANCE, INC. d/b/a EMPIRE BLUE CROSS BLUE SHIELD,	)	
Plaintiff,	)	
v.	)	Civil Action No. 03-CV-2728 (DC)
DENISE FINN McVEIGH, as Administratrix of the Estate of JOSEPH E. McVEIGH,	)	
Defendant.	)	

DECLARATION IN SUPPORT OF OPPOSITION TO DEFENDANT'S MOTION TO DISMISS OR FOR SUMMARY JUDGMENT

KIERAN X. BASTIBLE affirms under penalty of perjury:

1. I am associated with the law firm of Morrison Cohen Singer & Weinstein, LLP, attorneys for Empire Blue Cross Blue Shield. As such, I am familiar with the facts and procedural history of this case. I submit this declaration in support of Empire's opposition to Defendant's motion to dismiss and for summary judgment. By submitting this declaration I place before the Court the pertinent exhibits for the Court's consideration of Empire's opposition to Defendant's dismissal and summary judgment motion.

2. Attached as Exhibit A to this declaration is the affidavit of Clinton Shatzer.

3. Attached as Exhibit B to this declaration is a true copy of H.R. Rep. No. 105-374, a report of the U.S. House of Representatives Committee on Government Reform and Oversight concerning the Federal Employees Health Care Protection Act of 1997.

4. Attached as Exhibit C to this declaration is a true copy of the transcript of the settlement conference held March 19, 2003, in New York State Supreme Court, Suffolk County, in the matter of *Finn v. Town of Southampton*, Index No. 011335/98 (Suffolk County).

Respectfully submitted,

By: /s/
Kieran X. Bastible